Oregon Administrative Rules

Chapter 436

Oregon Department of Consumer and Business Services
Workers' Compensation Division

April 1, 2016

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OREGON ADMINISTRATIVE RULES

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PLEASE NOTE: This is a complete compilation of chapter 436 of the Oregon Administrative Rules as of April 1, 2016. Please contact the Workers' Compensation Division to find out about recently issued rules (with future effective dates), or visit the division's website: **wcd.oregon.gov** and select "Laws & Rules."

ADMINISTRATIVE ORDER NUMBERS: For each rule division, we have listed the most recent administrative order number at the top of the page. However, the reader should refer to the history references at the end of each rule to see which administrative orders revised that rule

HISTORY LINES: These rules include only the most recent "History" lines. The history line shows when the rule was last revised and its effective date. To obtain a comprehensive history for OAR chapter 436, please visit the division's website: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

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CHAPTER 436, DIVISION 001
OREGON ADMINISTRATIVE RULES

PROCEDURAL RULES, RULEMAKING, HEARINGS, AND ATTORNEY FEES

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436-001-0003 Applicability and Purpose of these Rules

(1) OAR 436-001-0005 through 436-001-0009 establish supplemental procedures for rulemaking under ORS chapter 183 and apply to all division rulemaking on or after Jan. 1, 2010.

(2) OAR 436-001-0019 through 436-001-0300 establish supplemental procedures for hearings on matters within the director's jurisdiction.

(a) In general, the rules of the Workers' Compensation Board in OAR chapter 438 apply to the conduct of hearings, unless these rules provide otherwise.

(b) These rules do not apply to hearings requested under ORS 656.740.

(c) These rules apply to hearings held on or after Jan. 1, 2016.

(3) OAR 436-001-0400 through 436-001-0440 apply to attorney fees awarded by the director under ORS 656.262, 656.277, and 656.386, and to attorney fees awarded by the director or administrative law judge under ORS 656.385(1).

(a) These rules apply to orders issued and attorney fees incurred on or after Jan. 1, 2016, regardless of the date on which the claim was filed.

(b) For attorney fees that are ordered to be paid in reconsideration proceedings under ORS 656.268(6), OAR 436-030-0175 applies.

(4) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(5) OAR 436-001-0500 applies to any refund or credit processed by the director on or after Jan. 1, 2016, regardless of the date on which the payment was received.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704, ORS ch. 183
Hist.: Amended 12/10/15 as WCD Admin. Order15-065, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0004 Definitions

(1) The following definitions apply to these rules, unless the context requires otherwise.

(a) "Administrative law judge" means an administrative law judge appointed by the Workers' Compensation Board, as defined in OAR 438-005-0040.

(b) "Board" means the Workers' Compensation Board and includes its Hearings Division.

(c) "Delivered" means physical delivery to the division's Salem office during regular business hours.

(d) "Director" means the director of the Department of Consumer and Business Services or the director's designee.

(e) "Division" means the Workers' Compensation Division.

(f) "Filed" means mailed, faxed, e-mailed, delivered, or otherwise submitted to the division in a method allowable under these rules.

(g) "Final order" means a final, written action of the director.

(h) "Mailed" means addressed to the last known address, with sufficient postage and placed in the custody of the U.S. Postal Service.

(i) "Party" may include, but is not limited to, a worker, an employer, an insurer, a self-insured employer, a managed care organization, a medical provider, or the division.

(j) "Proposed and final order" means an order subject to revision by the director that becomes final unless exceptions are

timely filed or the director issues a notice of intent to review the proposed and final order.

(2) Other words and phrases have the same meaning as given in ORS 183.310, where applicable.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704, ORS ch. 183
Hist.: Amended 12/10/15 as WCD Admin. Order15-065, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

Rulemaking

436-001-0005 Model Rules for Rulemaking

The Model Rules for Rulemaking, OAR 137-001-0005 through 137-001-0100, in effect on Jan. 1, 2008, adopted by the Oregon Department of Justice under ORS 183.341, are adopted as the rules of procedure for rulemaking actions of the Workers' Compensation Division.

{ED. NOTE: The full text of the Model Rules is available from the Department of Justice, the Workers' Compensation Division, or on the Oregon State Archives website: http://arcweb.sos.state.or.us/pages/rules/oars_100/oar_137/137_001.html.}

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 183.325 through 183.410
Hist: Amended 11-16-12 as WCD Admin. Order 12-060, eff. 12-28-12
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0009 Notice of Division Rulemaking

(1) Except when adopting a temporary rule, the division will give prior public notice of the proposed adoption, amendment, or repeal of any rule by:

(a) Publishing notice of the proposed rulemaking action in the Secretary of State's Oregon Bulletin at least 21 days before the effective date of the rule;

(b) Notifying interested people and organizations on the division's notification lists of proposed rulemaking actions under ORS 183.335; and

(c) Providing notice to legislators as required by ORS 183.335(15).

(2) A person or organization may elect to receive email or hard-copy notification of proposed rulemaking actions conducted by the division.

(a) A person or organization may elect to subscribe to the division's e-mail notification service at: https://service.govdelivery.com/accounts/ORDCBS/subscriber/new.

(b) A person or organization may elect to receive hard-copy notification by sending a request in writing, including the person or organization's full name and mailing address, to the following address:

Rules Coordinator, Operations Section/Policy Team
Workers' Compensation Division
350 Winter Street NE, PO Box 14480
Salem OR 97309-0405

Stat. Auth.: ORS 656.726 (4)
Stats. Implemented: ORS 183.335 and 84.022
Hist.: Amended 12/10/15 as WCD Admin. Order15-065, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

Hearings

436-001-0019 Requests for Hearing

(1) A request for hearing on a matter within the director's jurisdiction must be filed with the division no later than the filing deadline. Filing deadlines will not be extended except as provided in section (7) of this rule.

(2) A request for hearing must be in writing. A party may use the division's Form 2839. A request for hearing must include the following information, as applicable:

(a) The name, address, and phone number of the party making the request;

(b) Whether the party making the request is the worker, insurer, medical provider, employer, any other party, or an attorney on behalf of a party;

(c) The number of the administrative order being appealed;

(d) The worker's name, address, and phone number;

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

(f) The date of injury;

(g) The insurer's or self-insured employer's claim number;

(h) The division's file number; and

(i) The reason for requesting a hearing.

(3) Requests for hearing may be filed in any of the following ways:

(a) By mail, to the following address:

Hearings Coordinator, Operations Section/Policy Team
Workers' Compensation Division
350 Winter Street NE, PO Box 14480
Salem OR 97309-0405

(b) By hand-delivery, to the following address:

Hearings Coordinator, Operations Section/Policy Team
Workers' Compensation Division
350 Winter Street NE, 2nd floor
Salem OR 97301

(c) By fax, to 503-947-7514, if the document transmitted indicates that it has been delivered by fax, is sent to the correct fax number, and indicates the date the document was sent.

(d) By e-mail, to wcd.hearings@oregon.gov. If the request for hearing is an attachment to the e-mail, it must be in a format that Microsoft Word 2010® (.docx, .doc, .txt, .rtf) or Adobe Reader® (.pdf) can open. Image formats that can be viewed in Internet Explorer® (.tif, .jpg) are also acceptable.

(e) By using the online form, available on the division's website.

(4) The requesting party must send a copy of the request to all known parties and their legal representatives, if any.

(5) Timeliness of requests for hearing will be determined under OAR 436-001-0027.

(6) The director will refer timely requests for hearing to the board for a hearing before an administrative law judge. The

director may withdraw a matter that has been referred if the request for hearing is premature, if the issues in dispute become moot, or if the director otherwise determines that the matter is not appropriate for hearing at that time.

(7) The director will deny requests for hearing that are filed after the filing deadline. The party may request a limited hearing on the denial of the request for hearing within 30 days after the mailing date of the denial. The request must be filed with the division. At the limited hearing, the administrative law judge may consider only whether:

(a) The denied request for hearing was filed timely; or

(b) Good cause existed that prevented the party from timely requesting a hearing on the merits. For the purpose of this rule, "good cause" includes, but is not limited to, mistake, inadvertence, surprise, or excusable neglect.

Stat. Auth.: ORS 656.726(4) and ORS 84.013
Stats. Implemented: ORS 656.704
Hist.: Amended 12/10/15 as WCD Admin. Order15-065, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0023 Other Filings and Submissions

(1) Except as provided in section (3) of this rule, any filing, motion, request, document, or correspondence filed or submitted in a matter within the director's jurisdiction must be filed or submitted:

(a) To the division before the dispute is referred to the board;

(b) To the administrative law judge after the dispute is referred to the board but before the administrative law judge issues a proposed and final order; and

(c) To the division after the administrative law judge issues a proposed and final order, unless it is a request for correction of errors in the proposed and final order under OAR 436-001-0246(7).

(2) A copy of any filing, motion, request, document, or correspondence must be sent to the other parties, or their legal representatives, at the same time it is filed or submitted to the division or administrative law judge.

(3) A party must notify the division and the other parties of any changes in the party's mailing address or legal representation.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704
Hist.: Amended 11-16-12 as WCD Admin. Order 12-060, eff. 12-28-12
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0027 Timeliness; Calculation of Time

(1) Timeliness of any document required by these rules to be filed or submitted to the division is determined as follows:

(a) If a document is mailed, it will be considered filed on the date it is postmarked.

(b) If a document is faxed or e-mailed, it must be received by the division by 11:59 p.m. Pacific time to be considered filed on that date.

(c) If a document is delivered, it must be delivered during regular business hours to be considered filed on that date.

(2) The date and time of receipt for electronic filings is determined under ORS 84.043.

(3) Time periods allowed for a filing or submission to the division are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

(4) If an employer or insurer receives a written request for hearing or administrative review from a worker, and the request should have been filed with the division, the employer or insurer must promptly forward the request to the division.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704
Hist.: Amended 12/10/15 as WCD Admin. Order15-065, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0030 Role of the Workers' Compensation Division

(1) In any hearing, the director may request to:

(a) Receive notice of all matters;

(b) Receive copies of all documents; and

(c) Present evidence, testimony, and argument.

(2) The director may appear in a matter by filing an entry of appearance. The director may be represented by an agency representative, assistant attorney general, or special assistant attorney general as authorized by the Department of Justice. If the director enters an appearance, all notices and documents in the hearing must be provided to the director's representative. An agency representative may represent the director in the following categories of hearings:

(a) Hearings held before the administrative law judges of the Workers' Compensation Board to determine the correctness of:

(A) An order under ORS 656.052 declaring a person, as defined in ORS 656.005(23), to be a noncomplying employer ("NCE Orders");

(B) A nonsubjectivity determination under ORS 656.052 declaring either that a person, as defined in OR5 656.005(23), is not a subject employer or is not a subject worker ("NSD Orders");

(C) An order assessing a civil penalty under ORS 656.735, 656.740, 656.745(2), or 656.750;

(D) An order under ORS 656.745(1) assessing a civil penalty against an employer or insurer with prior written consent of the Attorney-in-Charge of the Business Activities Section of the Department of Justice; and

(E) An order under ORS 656.254(2) imposing sanctions to enforce medical reporting requirements.

(b) In cases assigned to lay representatives in accordance with subsection (a), above:

(A) Lay representatives are authorized to handle all settlement negotiations related to proposed NCE Orders, NSD Orders, and civil penalty or forfeiture orders. All settlement documents will be reviewed for legal sufficiency by the Department of Justice unless they conform to a form settlement document approved by the Attorney-in-Charge of the Business Activities Section.

All settlement documents submitted to the Department of Justice will be accompanied by the original proposed order and any subsequent orders issued by the division.

(B) If the division issues a worker nonsubjectivity denial instead of referring the claim to the assigned claims agent, the division's lay representative(s) may handle settlement negotiations resulting from that worker nonsubjectivity denial. Once a request for hearing has been filed contesting that worker nonsubjectivity denial, the lay representative(s) have seven calendar days within which to finalize any pending settlement negotiations and must coordinate settlement discussions with the assigned assistant attorney general or special assistant attorney general, who will assume representation on the case. The assistant attorney general or special assistant attorney general assigned to the case may extend the seven-day time period by authorizing the lay representative(s) to continue settlement negotiations. All settlement documents will be reviewed for legal sufficiency by the attorney assigned to the case before submission to an administrative law judge.

(c) Notwithstanding subsections (a) or (b) above, and under ORS 656.704, the Department of Justice will represent the division in all matters pertaining to a claim.

(3) The administrative law judge must not allow an agency representative appearing under section (2) of this rule to present legal argument as defined by this rule.

(a) "Legal argument" includes arguments on:

(A) The jurisdiction of the agency to hear the contested case;

(B) The constitutionality of a statute or rule or the application of a constitutional requirement to an agency; and

(C) The application of court precedent to the facts of the particular contested case proceeding.

(b) "Legal argument" does not include presentation of motions, evidence, examination and cross-examination of witnesses, or presentation of factual arguments or arguments on:

(A) The application of the statutes or rules to the facts in the contested case;

(B) Comparison of prior actions of the agency in handling similar situations;

(C) The literal meaning of the statutes or rules directly applicable to the issues in the contested case;

(D) The admissibility of evidence; and

(E) The correctness of procedures being followed in the contested case hearing.

(4) If the administrative law judge determines that statements or objections made by an agency representative appearing under section (2) involve legal argument as defined in this rule, the administrative law judge must provide reasonable opportunity for the agency representative to consult the Attorney General and permit the Attorney General to present argument at the hearing or to file written legal argument within a reasonable time after conclusion of the hearing.

(5) An agency representative appearing under section (2) must read and be familiar with the Code of Conduct for Non-Attorney Representatives at Administrative Hearings dated June 1, 2011, as amended October 1, 2011, which is maintained by the Oregon Department of Justice and available on its website at: http://www.doj.state.or.us/help/pdf/code_of_conduct_oah_contested.pdf.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 180.220(2), 180.235, and 656.704
Hist.: Amended 12/10/15 as WCD Admin. Order15-065, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0170 Duties and Powers of the Administrative Law Judge

(1) The administrative law judge may conduct the hearing in any manner, consistent with these rules, that will achieve substantial justice.

(2) Unless provided otherwise by statute or rule and except as stated in section (3) of this rule, any order issued by an administrative law judge regarding a matter within the director's jurisdiction is a proposed and final order subject to review by the director under OAR 436-001-0246.

(3) When appropriate, the administrative law judge may issue an interim order. An interim order is not subject to review by the director under OAR 436-001-0246.

(4) The administrative law judge may dismiss requests for hearing as provided in OAR 436-001-0296.

(5) When appropriate, the administrative law judge may remand a dispute to the director for further administrative action.

(6) The administrative law judge may consolidate matters in which there are common parties or common issues of law or fact.

(7) The administrative law judge may separate matters to promote efficient disposition of the matters.

(8) Consolidation of matters under section (6) of this rule or under ORS 656.704(3)(c) is only for the purpose of hearing. The administrative law judge must issue a separate order for matters other than those concerning a claim.

(9) On the motion of a party, the division, or the administrative law judge, the administrative law judge may continue a hearing to allow the presentation of oral or written legal argument by the Department of Justice.

(10) The administrative law judge may send the division a written question regarding which rules or statutes apply to a matter, or regarding the division's interpretation of the rules and statutes. If the administrative law judge sends such a question, the administrative law judge must provide a written summary of the context in which the question arises, provide a reasonable time for the division to respond, and send a copy to all parties.

(11) The administrative law judge may conduct a hearing by telephone if all parties agree.

Stat. Auth.: Stat. Auth.: ORS 183.452, 656.704, 656.726(4)
Stats. Implemented: ORS 180.220(2), 180.235, 183.452, and 656.704
Hist: Amended 12/10/15 as WCD Admin. Order15-065, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0225 Scope of Review/Limitations on the Record

(1) Except for the matters listed in sections (2) and (3), the administrative law judge reviews all matters within the director's jurisdiction de novo, unless otherwise provided by statute or administrative rule.

(2) In medical service and medical treatment disputes under ORS 656.245, 656.247(3)(a), and 656.327, and managed care disputes under ORS 656.260(16), the administrative law judge may modify the director's order only if it is not supported by substantial evidence in the record or if it reflects an error of law. New evidence or issues may not be admitted or considered.

(3) In vocational assistance disputes under ORS 656.340, new evidence may be admitted and considered. Under ORS 656.340(16), the administrative law judge may modify the director's order only if it:

(a) Violates a statute or rule;

(b) Exceeds the director's statutory authority;

(c) Was made upon unlawful procedure; or

(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.247, 656.260, 656.327, 656.340, 656.704
Hist.: Amended 11-16-12 as WCD Admin. Order 12-060, eff. 12-28-12
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0240 Exhibits and Evidence

(1) Within 21 days after referral of the request for hearing to the board, the division will provide the parties and the administrative law judge copies of all documents that were relied upon in the underlying action or order, with an index.

(2) Not less than 28 days before the hearing, or within seven days of receipt of the division's document index and documents, whichever is later, the petitioner(s) must provide copies of any additional exhibits they will offer at hearing to the other parties, the administrative law judge, and the director's representative, if the director has filed an entry of appearance. The exhibits must be marked and include a supplemental index, numbered to coincide in chronological order with the division's exhibits and exhibit list. For example, an exhibit that is chronologically between the division's exhibits 5 and 6 would be marked as "Exhibit 5a" or "Ex. 5a."

(3) Not less than 14 days before the hearing, the respondent(s) and cross-petitioner(s) must provide copies of any additional exhibits they will offer at hearing to the other parties, the administrative law judge, and the director's representative, if the director has filed an entry of appearance. The exhibits must be marked and indexed in the same manner as provided in section (2).

(4) Unless withdrawn, all exhibits offered will be included in the hearing file, whether or not they are admitted into the evidentiary record.

(5) At the discretion of the administrative law judge, an accurate description or photograph of an object or real evidence may be substituted for the object or real evidence. The party offering the evidence is responsible for providing the description or photograph, and for retaining custody of the object until the case is closed.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704
Hist.: Amended 12/10/15 as WCD Admin. Order15-065, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0246 Proposed and Final Orders - Exceptions, Correction, Director Review

(1) Under ORS 656.704(2)(a), a party must seek director review of a proposed and final order before petitioning for judicial review under ORS 183.482.

(2) The parties or the division may initiate director review of a proposed and final order by filing exceptions as follows:

(a) Written exceptions, including any argument, must be filed with the division within 30 days of the mailing date of the proposed and final order.

(b) A written response to the exceptions must be filed within 20 days of the date the exceptions were filed.

(c) A written reply to the response, if any, must be filed within 10 days of the date the response was filed.

(d) Exceptions, responses, and replies may be filed in any of the following ways:

(A) By mail, to the following address:

Hearings Coordinator, Operations Section/Policy Team

Workers' Compensation Division

350 Winter Street NE, PO Box 14480

Salem OR 97309-0405

(B) By hand-delivery, to the following address:

Hearings Coordinator, Operations Section/Policy Team

Workers' Compensation Division

350 Winter Street NE, 2nd floor

Salem OR 97301

(C) By fax, to 503-947-7514, if the document transmitted indicates that it has been delivered by fax, is sent to the correct fax number, and indicates the date the document was sent.

(D) By e-mail, to wcd.hearings@oregon.gov. If the exception, response, or reply is in an attachment to the e-mail, the attachment must be in a format that Microsoft Word 2010® (.docx, .doc, .txt, .rtf) or Adobe Reader® (.pdf) can open. Image formats that can be viewed in Internet Explorer® (.tif, .jpg) are also acceptable.

(3) The director may extend the time periods in section (2) upon a party's written request that explains the need for the delay, or on the director's own motion.

(4) If exceptions are timely filed, the director may issue a final order or an amended proposed and final order, request the administrative law judge to hold further hearing, or remand the matter for further administrative action.

(5) Within 30 days of the mailing date of the proposed and final order, the director may issue a notice of intent to review the proposed and final order, even if no exceptions are filed.

(6) All proposed and final orders must contain language notifying the parties of their right to file exceptions, how to file, and the timeframes.

(7) The administrative law judge may withdraw a proposed and final order for correction of errors within 10 calendar days of the mailing date of the order. The time for filing exceptions begins on the date the corrected proposed and final order is mailed.

(8) If no exceptions are timely filed or if no notice of intent to review is issued, the proposed and final order will become final 30 days after the mailing date of the order.

(9) Any requests for review or requests for reconsideration of a proposed and final order filed with the board or administrative law judge within 30 days of the mailing date of the order will be forwarded to the director and treated as timely exceptions under this rule.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704
Hist.: Amended 12/10/15 as WCD Admin. Order15-065, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0252 Stay of Director and Administrative Review

(1) A party may request that director review be stayed if exceptions are timely filed and there is a pending matter concerning a claim that may make the matter within the director's jurisdiction moot.

(2) If matters are consolidated under ORS 656.704(3)(c), and a party requests board review of the order for those matters concerning a claim, and a party files exceptions on the proposed and final order for matters other than those concerning a claim, the director may stay director review of the proposed and final order. If director review is stayed, the parties will be provided the opportunity to file a written response and reply as provided in OAR 436-001-0246, and director review will then be stayed until the board issues an order for those matters concerning a claim.

(3) If matters are consolidated under ORS 656.704(3)(c), and a party requests board review of the order for those matters concerning a claim, and the administrative law judge remands the matters other than those concerning a claim to the director for further administrative action, the director may stay further administrative action until the board issues an order for those matters concerning a claim.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704
Hist.: Amended 6/12/08 as WCD Admin. Order 08-050, eff. 7/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0259 Ex Parte Communication

An ex parte communication is an oral or written communication to the director during director review of the matter not made in the presence of all parties to the dispute, concerning a fact in issue, but does not include communication from division staff or the Department of Justice about legal issues or facts in the record. Ex parte communications received during director review will be promptly disclosed to all parties, and the parties will be allowed a reasonable opportunity to respond.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704, OL 2005 ch 26
Hist.: Adopted 10/19/05 as WCD Admin. Order 05-061 eff. 1/2/06
Amended 12/10/15 as WCD Admin. Order15-065, eff. 1/1/16

436-001-0296 Settlements and Dismissals

(1) If, after a request for hearing is filed but before a proposed and final order is issued, an agreement under ORS 656.236 or 656.289(4) is approved that resolves all issues in the matter within the director's jurisdiction, the administrative law judge may issue a proposed and final order dismissing the request for hearing.

(2) If, after a request for hearing is filed but before a proposed and final order is issued, the parties reach agreement on all issues in the matter within the director's jurisdiction, the administrative law judge may issue a proposed and final order approving the agreement and dismissing the request for hearing.

(3) If the matter within the director's jurisdiction is consolidated with matters concerning a claim and the parties reach agreement on all issues in the matter within the director's jurisdiction prior to issuance of a proposed and final order, the administrative law judge may issue a proposed and final order approving the agreement and dismissing the request for hearing.

(4) Notwithstanding OAR 436-001-0170(2), the administrative law judge may issue a final order of dismissal when the requesting party withdraws the request for hearing and no cross-request for hearing has been filed.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704
Hist.: Amended 6/12/08 as WCD Admin. Order 08-050, eff. 7/1/08

Attorney Fees

436-001-0400 General provisions and requirements for attorney fees awarded by the director

(1) In order to be awarded an attorney fee, the attorney must file with the director a signed attorney retainer agreement.

(2) In cases in which time devoted is a factor in determining the amount of the fee, the attorney should submit a statement of the number of hours spent on the case. If the attorney has submitted a statement of hours and then spends more time on the case, the attorney may submit an updated statement, which the director will consider if an order has not already been issued. If the attorney does not submit a statement of hours, the director will presume the attorney spent one to two hours on the case.

(3) In cases in which a reasonable fee is to be assessed, the director may consider the following factors:

(a) The time devoted to the case.

(b) The complexity of the issues involved.

(c) The value of the interest involved.

(d) The skill of the attorney and the quality of representation.

(e) The nature of the proceedings.

(f) The benefit secured for the worker.

(g) The risk in a particular case that an attorney's efforts may go uncompensated.

(h) The assertion of frivolous issues or defenses.

Stat. Auth.: ORS 656.385(1), 656.726(4)
Stats. Implemented: ORS 656.262, 656.385, 656.388, and 656.704
Hist.: Amended and renumbered 12-1-2009 from OAR 436-001-0265 as WCD Admin. Order 09-053, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0410 Attorney fees awarded under ORS 656.385(1)

(1) In cases in which the director or administrative law judge awards a fee under ORS 656.385(1):

(a) The fee must fall within the ranges of the matrix in subsection (1)(d), unless extraordinary circumstances are shown or the parties otherwise agree.

(b) Extraordinary circumstances are not established merely by exceeding eight hours or a benefit of $6,000.

(c) The matrix in subsection (1)(d) shows the maximum fee and fee ranges as percentages of the maximum fee under ORS 656.385(1), as adjusted annually by the same percentage increase, if any, to the average weekly wage defined in ORS 656.211. Before July 1 of each year the director will publish, in Bulletin 356 (available on the division's website), the matrix showing the maximum fee and fee ranges as dollar amounts after the annual adjustment to the statutory maximum fee. Dollar amounts will be rounded to the nearest whole dollar. If the average weekly wage does not change or decreases, the maximum attorney fee awarded under ORS 656.385(1) will not be adjusted for that year.

(d)

Estimated Benefit Achieved	**Professional Hours Devoted (Fees as percentage of adjusted maximum attorney fee under ORS 656.385(1))**		
	1-4 hours	**4.1-8 hours**	**over 8 hours**
$1-$2,000	5.0% - 35.0%	15.0% - 50.0%	40.0% - 62.5%
$2,001-$4,000	10.0% - 40.0%	30.0% - 65.0%	52.5% - 75.0%
$4,001-$6,000	15.0% - 50.0%	40.0% - 72.5%	65.0% - 87.5%
Over $6000	20.0% - 65.0%	52.5% - 90.0%	77.5% - 100.0%

(2) For purposes of applying the matrix in medical disputes under ORS 656.245, 656.247, 656.260, and 656.327, the following may be considered in determining the value of the results achieved or the benefit to the worker:

(a) The fee allowed by the medical fee schedule in OAR 436-009 for the medical service at issue.

(b) The overall cost of the medical service at issue.

(3) For purposes of applying the matrix in vocational disputes under ORS 656.340, the value of vocational assistance or a training plan, unless determined to be otherwise, falls within the highest range of the matrix for "benefit achieved." In addition, the following may be considered in determining the value of the results achieved or the benefit to the worker:

(a) The actual or projected cost of the service at issue.

(b) The maximum spending limit in the fee schedule for vocational assistance costs in OAR 436-120-0720 for the service at issue.

Stat. Auth.: ORS 656.385(1), 656.726(4)
Stats. Implemented: ORS 656.262, 656.385, 656.388, and 656.704
Hist.: Amended 12/10/15 as WCD Admin. Order15-065, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0420 Attorney fees awarded under ORS 656.262(11)

In cases in which the director awards a fee under ORS 656.262(11):

(1) OAR 438-015-0110 applies.

(2) The director may use the matrix in OAR 436-001-0410 as a guide in determining the amount of the fee.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.262
Amended 12/10/15 as WCD Admin. Order15-065, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0430 Attorney fees awarded under ORS 656.262(12)

The matrix for determining the amount of the attorney fee assessed under ORS 656.262(12) is in OAR 436-060, Appendix "D" (436-060-0400).

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.262
Amended 11-16-12 as WCD Admin. Order 12-060, eff. 12-28-12
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-001-0435 Attorney fees awarded under ORS 656.277(1)

(1) Attorney fees assessed under ORS 656.277(1) will be based on a reasonable hourly rate multiplied by the time devoted by the attorney to obtaining the reclassification order.

(2) The director will determine a reasonable hourly rate of no less than $150 per hour and no more than $400 per hour.

(3) When determining the time devoted by the attorney to obtaining the reclassification order, the director may consider time devoted by the attorney to requesting reclassification from the insurer or self-insured employer and investigating issues related to the classification of the worker's claim.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.277(1); 2015 Or Laws, ch. 521, section 3
Hist: Adopted 12/10/15 as WCD Admin. Order15-065, eff. 1/1/16

436-001-0440 Time within which attorney fees must be paid

Attorney fees assessed under OAR 436-001-0400 to 436-001-0440 must be paid within 30 days of the date the order awarding the fees becomes final.

Stat. Auth.: ORS 656.385(1), 656.726(4)
Stats. Implemented: ORS 656.262, 656.385, 656.388, and 656.704
Adopted 12-1-2009 as WCD Admin. Order 09-053, eff. 1-1-2010

Overpayments

436-001-0500 Refund of overpayments

When the director receives a payment in excess of the amount legally due and payable to the director, the director will refund or credit the excess amount. However, when the excess amount is less than $20 and the payment was for an assessment or civil penalty issued under OAR chapter 436 or ORS chapter 656, the director will refund or credit the excess amount only if a written request for refund or credit is received within two years of the date that the excess amount was received by the director.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.506, 656.612, 656.614, 656.735, 656.745, 656.750, 656.780, and 293.445
Hist: Adopted 12/10/15 as WCD Admin. Order 15-065, eff. 1/1/16

CHAPTER 436, DIVISION 008
OREGON ADMINISTRATIVE RULES

ELECTRONIC MEDICAL BILLING

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436-008-0001 Authority, Applicability, Purpose, and Administration of these Rules

(1) These rules are promulgated under the director's authority contained in ORS 656.726(4) and specific authority under ORS 656.252.

(2) These rules apply to all electronic medical billing transactions generated on or after the effective date of these rules.

(3) The purpose of these rules is to establish uniform guidelines for the exchange of electronic medical billing transactions within the workers' compensation system.

(4) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(5) Orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 are considered orders of the director.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254, 656.726(4)
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0004 Adoption of Standards

(1) The director adopts, by reference, the following electronic medical bill processing standards:

(a) Professional Billing:

(A) The Accredited Standards Committee X12 (ASC X12) Standards for Electronic Data Interchange (EDI) Type 3 Technical Reports (TR3);

(B) Health Care Claim: Professional (837), May 2006, ASC X12, 005010X222; and

(C) Type 3 Errata to Health Care Claim: Professional (837), June 2010, ASC X12, 005010X222A1.

(b) Institutional/Hospital Billing:

(A) The ASC X12 Standards for EDI TR3;

(B) Health Care Claim: Institutional (837), May 2006, ASC X12, 005010X223;

(C) Type 1 Errata to Health Care Claim: Institutional (837);

(D) ASC X12 Standards for EDI TR3, October 2007, ASC X12, 005010X223A1; and

(E) Type 3 Errata to Health Care Claim: Institutional (837), June 2010, ASC X12, 005010X223A2.

(c) Dental Billing:

(A) The ASC X12 Standards for EDI TR3;

(B) Health Care Claim: Dental (837), May 2006, ASC X12, 005010X224;

(C) Type 1 Errata to Health Care Claim: Dental (837);

(D) ASC X12 Standards for EDI Technical Report Type 3, October 2007, ASC X12, 005010X224A1; and

(E) Type 3 Errata to Health Care Claim: Dental (837), June 2010, ASC X12, 005010X224A2.

(d) Retail Pharmacy Billing:

(A) The Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, National Council for Prescription Drug Programs (NCPDP); and

(B) The Batch Standard Batch Implementation Guide, Version 1, Release 2 (Version 1.2), January 2006, NCPDP.

(e) Remittance:

(A) The ASC X12 Standards for EDI TR3, Health Care Claim Payment/Advice (835), April 2006, ASC X12, 005010X221; and

(B) Type 3 Errata to Health Care Claim Payment/Advice (835), June 2010, ASC X12, 005010X221A1.

(2) The director adopts, by reference, the following electronic standards for medical bill acknowledgments:

(a) The ASC X12 Standards for EDI TA1 Interchange Acknowledgment contained in the standards adopted under section (1) of this rule;

(b) The ASC X12 Standards for EDI TR3, Implementation Acknowledgment for Health Care Insurance (999), June 2010, ASC X12, 005010X231A1;

(c) The ASC X12 Standards for EDI TR3, Health Care Claim Acknowledgment (277CA), January 2007, ASC X12, 005010X214; and

(d) Electronic responses to NCPDP transactions, and the response contained in the standards adopted under subsection (1)(d).

(3) The director adopts, by reference, the ASC X12N 275 - Additional Information to Support a Health Claim or Encounter, Version 005010, February 2008, 005010X210, for attachments to medical bills.

(4) The director adopts, by reference, the ASC X12N/2013-57, effective Dec. 2013, Code Value Usage in Health Care Claim Payments and Subsequent Claims Technical Report Type 2.

(5) ASC X12N and the ASC X12 standards for EDI may be purchased from the ASC X12, 7600 Leesburg Pike, Suite 430, Falls Church, VA 22043; telephone 703-970-4480; and fax 703-970-4488. They are also available for purchase through the internet at http://www.X12.org.

(6) Retail pharmacy standards may be purchased from the NCPDP, 9240 East Raintree Drive, Scottsdale, AZ 85260, telephone 480-477-1000; fax 480- 767-1042. They are also available, for purchase, through the Internet at http://www.ncpdp.org.

(7) The director adopts the Oregon Workers' Compensation Division Electronic Billing and Payment Companion Guide Release 1.0, Jan. 1, 2015. A copy of the guide is available at the following website: http://wcd.oregon.gov/insurer/edi/Pages/ebilling.aspx.

(8) Copies of the standards referenced in this rule are available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301, 503-947-7717.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0005 Definitions

For the purpose of these rules and the Oregon Electronic Billing and Payment Companion Guide:

(1) "Clearinghouse" means an entity that is an authorized agent of the insurer or health care provider, including billing services, re-pricing companies, community health management information systems or community health information systems, and "value-added" networks and switches that does either of the following functions:

(a) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(b) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

(2) "Companion guide" means the Oregon Workers' Compensation Division Electronic Billing and Payment Companion Guide adopted by the division in these rules that provides standards for workers' compensation electronic billing transactions.

(3) "Complete electronic bill submission" means an electronic medical billing transaction that is populated with current and valid values defined in the applicable standard set forth in OAR 436-008-0004 that:

(a) Includes the correct billing format, with the correct billing code sets;

(b) Is transmitted in compliance with all necessary format requirements; and

(c) Contains, in legible text, all supporting documentation that is expressly required by law or can reasonably be expected by the payer or its agent under the jurisdiction's law.

(4) "Days" means calendar days. For calendar days, the first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

(5) "Director" means the director of the Department of Consumer and Business Services.

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

(7) "Electronic" refers to a communication between computerized data exchange systems that complies with the standards set forth in these rules.

(8) "Explanation of benefits (EOB)" means an electronic remittance advice (ERA) or notification, sent or made available electronically by the insurer or an authorized agent of the insurer, to the health care provider, health care facility, or third-party biller or assignee regarding payment or denial of a bill, reduction of a bill, or refund.

(9) "Insurer" means:

(a) The State Accident Insurance Fund Corporation;

(b) An insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon;

(c) An insurer-authorized agent or payer;

(d) An assigned claims agent selected by the director under ORS 656.054; or

(e) An employer or employer group that has been certified under ORS 656.430 meeting the qualifications of a self-insured employer under ORS 656.407.

(10) "Medical Bill" means a statement of charges for medical services.

(11) "Payer" means the insurer or an entity authorized to make payments on behalf of the insurer.

(12) "Supporting documentation" means those documents necessary for the insurer to process a bill, including but not limited to medical reports and records, evaluation reports, narrative reports, assessment reports, progress report/notes, chart notes, hospital records, and diagnostic test results.

(13) "Trading partner" means any entity that exchanges information electronically with another entity.

Stat. Auth.: ORS 656 252, 656.726(4)
Stats. Implemented: ORS 656.726(4)
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0010 Electronic Medical Bills

(1) Beginning Jan. 1, 2015, insurers must accept and process all electronically transmitted medical bills in accordance with these rules, the standards adopted under OAR 436-008-0004, and the companion guide.

(2) An insurer is exempt from the requirement to accept medical bills electronically from health care providers on or

after Jan. 1, 2015, if a written notice is sent to the division, and approved by the director, on or before close of business on Dec. 31, 2014. The notice must explain in detail that the cost of electronic medical bill implementation will create an unreasonable financial hardship.

(3) Health care providers that elect to submit electronic medical bills to insurers must do so in accordance with these rules, the standards adopted under OAR 436-008-0004, and companion guide.

(4) All electronic medical billing transactions must be populated with current and valid values defined in the applicable standard set forth in OAR 436-008-0004.

(5) The health care provider, health care facility, third-party biller or assignee and the insurer may mutually agree to use nonstandard formats, but those formats must include all data elements required under the applicable standard, as set forth in OAR 436-008-0004.

(6) Health care providers and insurers may contract with other entities for electronic medical bill processing.

(7) Insurers and health care providers are responsible for the acts or omissions of their agents executed in the performance of electronic medical billing services.

(8) The data elements transmitted as part of a Trading Partner Agreement must at a minimum contain all the same required data elements found within the ASC X12 Type 3 Technical Reports and the jurisdiction-specific companion guide.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0015 Electronic Medical Bill Attachments or Documentation

(1) A unique attachment indicator number must be assigned to all documentation. The attachment indicator number populated on the document must include the report type code, the report transmission code, the attachment control qualifier, and the attachment control number.

(2) Documentation in support of electronic medical bills may be submitted by fax, secure email, regular mail, electronic transmission using the prescribed format, or by a mutually agreed upon format.

(3) Documentation in support of electronic medical bills must be submitted within five days of submission of the bill and include the following elements:

(a) Patient name (ill or injured worker);

(b) Date of birth (if available);

(c) Employer name;

(d) Insurer name;

(e) Date of service;

(f) Claim number (if no claim number then use "UNKNOWN"); and

(g) Unique attachment indicator number.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0020 Electronic Medical Bill Acknowledgements

(1) If the electronic submission does not conform to the standards adopted under OAR 436-008-0004(1), then the insurer must send an acknowledgment adopted under OAR 436-008-0004(2)(a) or OAR 436-008-0004(2)(b) to the health care provider. This acknowledgement must be sent within one day of receipt of the electronic bill unless the electronic submission lacks sufficient identifiers to create an acknowledgment.

(2) If the electronic submission does conform to a standard adopted under OAR 436-008-0004(1), then the insurer must send an acknowledgment adopted under OAR 436-008-0004(2)(c) to the health care provider within two days.

(3) Any acknowledgment of a medical bill, as provided in (1) or (2) of this rule is not an admission of liability by the insurer.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0025 Electronic Medical Bill Payments

(1) Insurers that accept and process a complete electronic bill for services, under OAR 436-008-0010(1) (a) or (b), must pay for treatment related to the injury or disease, provided or authorized by the treating health care provider, on accepted claims within 14 days of any action causing the service to be payable, or within 45 days of receipt of the electronic bill, whichever is later.

(2) If an insurer requires additional information before a payment decision can be made, a request for this information must be made to the medical provider within 20 days of receipt of the bill.

(3) The insurer must provide an explanation (EOB) of services being paid or denied.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0030 Electronic Remittance Advice; Explanation of Benefits

(1) An electronic remittance advice (ERA) or notification is an explanation of benefits (EOB) that the insurer submits electronically regarding payment or denial of a bill, reduction of a bill, or refund. An insurer must submit an EOB no later than five days after generating a payment.

(2) The EOB must include:

(a) The amount of payment for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;

(b) The specific reason for non-payment, reduced payment, or discounted payment for each service billed; and

(c) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a health care provider's payment question within 48 hours, excluding weekends and legal holidays.

(3) The insurer must make available, to health care providers, the applicable information specified under OAR 436-009-0030(3)(c)(A) through (F), including:

"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the director of the Department of Consumer and Business Services. Your request for review must be made within 90 calendar days of the send/receive date of this explanation. To request a review, provide information that shows what you believe is incorrect about the payment, and send this information and required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, P.O. Box 14480, Salem, OR 97309-0405. You may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this information for your records."

(4) Any information required under sections (1) through (3) of this rule that cannot be submitted on the electronic EOB must be made available on the insurer's website or by any other means reasonably convenient for the EOB recipient.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0040 Assessment of Civil Penalties

Under ORS 656.745, the director may assess a civil penalty against an insurer that fails to comply with ORS chapter 656, the director's rules, or orders of the director.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.254, 656.745
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

Electronic Billing and Payment Companion Guide {LINK}

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 009

OREGON MEDICAL FEE AND PAYMENT RULES

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436-009-0001 Administration of These Rules

(1) Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.

(2) **Authority for Rules.**

These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) and specific authority under ORS 656.248.

(3) **Purpose.**

The purpose of these rules is to establish uniform guidelines for administering the payment for medical benefits to workers within the workers' compensation system.

(4) **Applicability of Rules.**

(a) These rules apply to all services rendered on or after the effective date of these rules.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist.: Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0004 Adoption of Standards *(Temporary Rule)*

(1) The director adopts, by reference, the American Society of Anesthesiologists ASA,

Relative Value Guide 2015 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide 2015, contact the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573, 847-825-5586, or on the Web at: http://www.asahq.org.

(2) The director adopts, by reference, the American Medical Association's (AMA) Current Procedural Terminology (CPT® 2016), Fourth Edition Revised, 2015, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT® must be used as guides governing the descriptions of services, except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.

(3) The director adopts, by reference, the AMA's CPT® Assistant, Volume 0, Issue 04 1990 through Volume 25, Issue 12, 2015. If there is a conflict between the CPT® manual and CPT® Assistant, the CPT® manual is the controlling resource.

(4) To get a copy of the CPT® 2016 or the CPT® Assistant, contact the American Medical Association, 515 North State Street, Chicago, IL60610, 800-621-8335, or on the Web at: http://www.ama-assn.org.

(5) The director adopts, by reference, only the alphanumeric codes from the CMS

Healthcare Common Procedure Coding System (HCPCS). These codes are to be used when billing for services, but only to identify products, supplies, and services that are not described by CPT® codes or that provide more detail than a CPT® code.

(a) Except as otherwise provided in these rules, the director does not adopt the HCPCS edits, processes, exclusions, color-coding and associated instructions, age and sex edits, notes, status indicators, or other policies of CMS.

(b) To get a copy of the HCPCS, contact the National Technical Information Service, Springfield, VA 22161, 800-621-8335 or on the Web at: www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

(6) The director adopts, by reference, CDT 2016: Dental Procedure Codes, to be used when billing for dental services. To get a copy, contact the American Dental Association at American Dental Association, 211 East Chicago Ave., Chicago, IL 60611-2678, or on the Web at: www.ada.org.

(7) The director adopts, by reference, the 02/12 1500 Claim Form and Version 1.1 06/13 (for the 02/12 form) 1500 Health Insurance Claim Form Reference Manual published by the National Uniform Claim Committee (NUCC). To get copies, contact the NUCC, American Medical Association, 515 N. State St., Chicago, IL 60654, or on the Web at: www.nucc.org.

(8) The director adopts, by reference, the Official UB-04 Data Specifications Manual 2015 Edition, published by National

Uniform Billing Committee (NUBC). To get a copy, contact the NUBC, American Hospital Association, One North Franklin, 29th Floor, Chicago, IL 60606, 312-422-3390, or on the Web at: www.nubc.org.

(9) The director adopts, by reference, the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.4 (7/2015) and the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) Version 1.1 – (5/2009). To get a copy, contact the National Council for Prescription Drug Programs (NCPDP), 9240 East Raintree Drive, Scottsdale, AZ 85260-7518, 480-477-1000, or on the Web at: www.ncpdp.org.

(10) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in ASA Relative Value Guide 2015, CPT® 2016, CPT® Assistant, HCPCS 2016, CDT 2016, Dental Procedure Codes, 1500 Health Insurance Claim Form Reference Instruction Manual, Official UB-04 Data Specifications Manual, or NCPDP Manual Claim Forms Reference Implementation Guide.

(11) Copies of the standards referenced in this rule are also available for review during regular business hours at the Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, Salem OR 97301, 503-947-7606.

Stat Auth: ORS 656.248, 656.726(4)
Stats Implemented: ORS 656.248
Hist: Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0005 Definitions

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made part of these rules.

(2) Abbreviations used in these rules are either defined in the rules in which they are used or defined as follows:

(a) CMS means Centers for Medicare & Medicaid Services.

(b) CPT® means Current Procedural Terminology published by the American Medical Association.

(c) DMEPOS means durable medical equipment, prosthetics, orthotics, and supplies.

(d) EDI means electronic data interchange.

(e) HCPCS means Healthcare Common Procedure Coding System published by CMS.

(f) ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3 by US Department of Health and Human Services.

(g) ICD-10-CM means International Classification of Diseases, Tenth Revision, Clinical Modification.

(h) MCO means managed care organization certified by the director.

(i) NPI means national provider identifier.

(j) OSC means Oregon specific code.

(k) PCE means physical capacity evaluation.

(l) WCE means work capacity evaluation.

(3) "**Administrative review**" means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001.

(4) "**Ambulatory surgery center**" (ASC) means:

(a) Any distinct entity licensed by the state of Oregon, and operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization; or

(b) Any entity outside of Oregon similarly licensed, or certified by Medicare or a nationally recognized agency as an ASC.

(5) "**Attending physician**" has the same meaning as described in ORS 656.005(12)(b). See Appendix A, "Matrix for Health Care Provider Types".

(6) "**Authorized nurse practitioner**" means a nurse practitioner licensed under ORS

678.375 to 678.390 who has certified to the director that the nurse practitioner has reviewed informational materials about the workers' compensation system provided by the director and who has been assigned an authorized nurse practitioner number by the director.

(7) "**Board**" means the Workers' Compensation Board and includes its Hearings Division.

(8) "**Chart note**" means a notation made in chronological order in a medical record in which the medical service provider records such things as subjective and objective findings, diagnosis, treatment rendered, treatment objectives, and return to work goals and status.

(9) "**Clinic**" means a group practice in which several medical service providers work cooperatively.

(10) "**CMS form 2552**" (Hospital and Hospital Health Care Complex Cost Report) means the annual report a hospital makes to Medicare.

(11) "**Current procedural terminology**" or "CPT"® means the Current Procedural

Terminology codes and terminology published by the American Medical

Association unless otherwise specified in these rules.

(12) "**Date stamp**" means to stamp or display the initial receipt date and the recipient's name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.

(13) "**Days**" means calendar days.

(14) "**Director**" means the director of the Department of Consumer and Business Services or the director's designee.

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

(16) "**Enrolled**" means an eligible worker has received notification from the insurer that the worker is being required to receive treatment under the provisions of a managed care organization (MCO). However, a worker may not be enrolled

who would otherwise be subject to an MCO contract if the worker's primary residence is more than 100 miles outside the MCO's certified geographical service area.

(17) "**Fee discount agreement**" means a direct contract entered into between a medical service provider or clinic and an insurer to discount fees to the medical service provider or clinic under OAR 436-009-0018.

(18) "**Hearings Division**" means the Hearings Division of the Workers' Compensation Board.

(19) "**Hospital**" means an institution licensed by the State of Oregon as a hospital.

(a) "**Inpatient**" means a patient who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

(b) "**Outpatient**" means a patient not admitted to a hospital prior to and extending past midnight for treatment and lodging. Medical services provided by a health care provider such as emergency room services, observation room, or short stay surgical treatments that do not result in admission are also considered outpatient services.

(20) "**Initial claim**" means the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared to be medically stationary by an attending physician or authorized nurse practitioner. For nondisabling claims, the "initial claim" means the first period of medical treatment immediately following the original filing of the occupational injury or disease claim ending when the attending physician or authorized nurse practitioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

(21) "**Insurer**" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in the state; or, an employer or employer group that has been certified under ORS 656.430 and meets the qualifications of a self-insured employer under ORS 656.407.

(22) "**Interim medical benefits**" means those services provided under ORS 656.247 on initial claims with dates of injury on or after January 1, 2002, that are not denied within 14 days of the employer's notice of the claim.

(23) "**Interpreter**" means a person who:

(a) Provides oral or sign language translation; and

(b) Owns, operates, or works for a business that receives income for providing oral or sign language translation. It does not include a medical provider, medical provider's employee, or a family member or friend of the patient.

(24) "**Interpreter services**" means the act of orally translating between a medical provider and a patient who speak different languages, including sign language. It includes reasonable time spent waiting at the location for the medical provider to examine or treat the patient as well as reasonable time spent on necessary paperwork for the provider's office.

(25) "**Mailed or mailing date**" means the date a document is postmarked. Requests submitted by facsimile or "fax" are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped by the Workers' Compensation Division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

(26) "**Managed care organization**" or "MCO" means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

(27) "**Medical provider**" means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.

(28) "**Medical service**" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.

(29) "**Medical service provider**" means a person duly licensed to practice one or more of the healing arts.

(30) "**Medical treatment**" means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker's condition through conservative care.

(31) "**Parties**" mean the worker, insurer, MCO, attending physician, and other medical provider, unless a specific limitation or exception is expressly provided for in the statute.

(32) "**Patient**" means the same as worker as defined in ORS 656.005(30).

(33) "**Physical capacity evaluation**" means an objective, directly observed, measurement of a patient's ability to perform a variety of physical tasks combined with subjective analyses of abilities by patient and evaluator. Physical tolerance screening, Blankenship's Functional Capacity Evaluation, and Functional Capacity Assessment have the same meaning as Physical Capacity Evaluation.

(34) "**Provider network**" means a health service intermediary other than an MCO that facilitates transactions between medical providers and insurers through a series of contractual arrangements.

(35) "**Report**" means medical information transmitted in written form containing relevant subjective or objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the director.

(36) "**Residual functional capacity**" means a patient's remaining ability to perform work-related activities. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the patient can perform each activity.

(37) "**Specialist physician**" means a licensed physician who qualifies as an attending physician and who examines a patient at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice or an opinion regarding the treatment being rendered, or considered, for a patient's compensable injury.

(38) "**Type A attending physician**" means an attending physician under ORS 656.005(12)(b)(A). See Appendix A, "Matrix for Health Care Provider Types".

(39) "**Type B attending physician**" means an attending physician under ORS 656.005(12)(b)(B). See Appendix A, "Matrix for Health Care Provider Types".

(40) "**Usual fee**" means the medical provider's fee charged to the general public for a given service.

(41) "**Work capacity evaluation**" means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work Tolerance Screening has the same meaning as Work Capacity Evaluation.

(42) "**Work hardening**" means an individualized, medically prescribed and monitored, work-oriented treatment process. The process involves the patient participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the patient to a specific job.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.000 et seq.; 656.005; 656.726(4)
Hist: Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0008 Request for Review by the Director

(1) **General.**

(a) Administrative review before the director:

(A) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all disputes concerning medical fees, non-payment of compensable medical bills, and medical service and treatment disputes arising under ORS 656.245, 656.247, 656.248, 656.260, 656.325, and 656.327. Disputes about whether a medical service provided after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c), or whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review before the director.

(B) A party does not need to be represented to participate in the administrative review before the director.

(C) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed.

(b) Except for disputes regarding interim medical benefits under ORS 656.247, when there is a formal denial of the compensability of the underlying claim, or a denial of the causal relationship between the medical service or treatment and the accepted condition or the underlying condition, the parties may file a request for hearing with the Hearings Division of the Workers' Compensation Board to resolve the compensability issue.

(2) **Time Frames and Conditions.**

(a) The following time frames and conditions apply to requests for administrative review before the director under this rule:

(b) For MCO-enrolled claims, a party that disagrees with an action or decision of the MCO must first use the MCO's dispute resolution process. If the party does not appeal the MCO's decision using the MCO's dispute resolution process, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision absent a showing of good cause. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision.

(c) For MCO-enrolled claims, if a party disagrees with the final action or decision of the MCO, the aggrieved party must request administrative review before the director within 60 days of the MCO's final decision. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 60-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. If a party has been denied access to the MCO dispute resolution process, or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process. If the MCO does not have a process for resolving a particular type of dispute, the insurer or the MCO must advise the medical provider or worker that they may request review before the director.

(d) For claims not enrolled in an MCO, or for disputes that do not involve an action or decision of an MCO:

(A) A worker must request administrative review before the director within 90 days of the date the worker knew, or should have known, there was a dispute over the provision of medical services. If the worker is represented, and the worker's attorney has given notice of representation to the insurer, the 90 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute.

(B) A medical provider must request administrative review within 90 days of the mailing date of the most recent explanation of benefits or a similar notification the provider received regarding the disputed service or fee. Rebillings without any relevant changes will not provide a new 90 day period to request administrative review.

(C) An insurer must request administrative review within 90 days of the date action on the bill was due under OAR 436-009-0030.

(D) For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute

is no later than one year from the claim denial, or 45 days after the bill is perfected, whichever occurs last. A request for administrative review under this rule may also be filed as prescribed in OAR chapter 438, division 005.

(e) Within 180 days of the date a bill is paid, an insurer may request a refund from a provider for any amount it determines was overpaid for a compensable medical service. If the provider does not respond to the request, or disagrees that a service was overpaid, the insurer may request director review within 90 days of requesting the refund.

(f) Medical provider bills for treatment or services that are under review before the director are not payable during the review.

(3) **Form and Required Information.**

(a) Requests for administrative review before the director should be made on Form 2842 as described in Bulletin 293. When an insurer or a worker's representative submits a request without the required information, the director may dismiss the request or hold initiation of the administrative review until the required information is submitted. Unrepresented workers may ask the director for help in meeting the filing requirements.

(A) The requesting party must simultaneously notify all other interested parties and their representatives, if known, of the dispute. The notice must:

(i) Identify the worker's name, date of injury, insurer, and claim number;

(ii) Specify the issues in dispute and the relief sought; and

(iii) Provide the specific dates of the unpaid disputed treatment or services.

(B) If the request for review is submitted by either the insurer or the medical provider, it must state specific codes of services in dispute and include enough documentation to support the request, including copies of original bills, chart notes, bill analyses, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to review the dispute. The insurer or medical provider requesting review must provide all involved parties a copy of:

(i) The request for review;

(ii) Any attached supporting documentation; and

(iii) If known, an indication of whether or not there is an issue of causation or compensability of the underlying claim or condition.

(b) In addition to medical evidence relating to the dispute, all parties may submit other relevant information, including written factual information, sworn affidavits, or legal argument, for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain additional evidence consistent with statute, such as pertinent medical treatment and payment records. The director may also interview parties to the dispute, or consult with an appropriate committee of the medical provider's peers. When a party receives a written request for additional information from the director, the party must respond within 14 days.

(c) When a request for administrative review is filed under ORS 656.247, the insurer must provide a record packet, at no charge, to the director and all other parties or their representatives as follows:

(A) The packet must include a complete, indexed copy of the worker's medical record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number must be preceded by the designation "Ex." and pagination of the multiple page documents must be designated by a hyphen followed by the page number. For example, page two of document 10 must be designated "Ex. 10-2." The index must include the document numbers, description of each document, author, number of pages, and date of the document. The packet must include the following notice in bold type:

We hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order that could affect reimbursement for the disputed medical service(s).

(B) If the insurer requests review, the packet must accompany the request, with copies sent simultaneously to the other parties.

(C) If the requesting party is other than the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer must provide the record within 14 days of the director's request as described in this rule.

(D) If the insurer fails to submit the record in the time and format specified in this rule, the director may sanction the insurer under OAR 436-010-0340.

(4) **Dispute Resolution by Agreement (Alternative Dispute Resolution).**

(a) A dispute may be resolved by agreement between the parties to the dispute. The agreement must be in writing and approved by the director. The director may issue a letter of agreement instead of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) A party fails to honor the agreement;

(B) The agreement was based on misrepresentation;

(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or

(D) All parties request revision or reinstatement of the dispute.

(b) Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney.

(5) **Director Order and Reconsideration.**

(a) The director may, on the director's own motion, reconsider or withdraw any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new information that could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request must be received by the director before the administrative order becomes final.

(b) During any reconsideration of the administrative order, the parties may submit new material evidence consistent with this rule and may respond to such evidence submitted by others.

(c) Any party requesting reconsideration or responding to a reconsideration request must simultaneously notify all other interested parties of its contentions and provide them with copies of all additional information presented.

(d) Attorney fees in administrative review will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 through 436-001-0440.

(6) **Hearings.**

(a) Any party that disagrees with an action or administrative order under these rules may obtain review of the action or order by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order under ORS 656.245, 656.248, 656.260, or 656.327, or within 60 days of the mailing date of an order under ORS 656.247. OAR 436-001 applies to the hearing.

(b) In the review of orders issued under ORS 656.245(3) or 656.247, no new medical evidence or issues will be admitted at hearing. In these reviews, an administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(c) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the board as follows:

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

(B) The request must be mailed to the division within 60 days after the mailing date of the order or notice of assessment.

(C) The division will forward the request and other pertinent information to the board.

(7) **Other Proceedings.**

(a) Director's administrative review of other actions not covered under sections (1) through (6) of this rule: Any party seeking an action or decision by the director, or any party aggrieved by an action taken by another party, may request administrative review before the director. Any party may request administrative review as follows:

(b) A written request for review must be sent to the administrator of the Workers' Compensation Division within 90 days of the disputed action and must specify the grounds upon which the action is contested.

(c) The division may require and allow such input and information as it deems appropriate to complete the review.

Stat. Auth.: ORS 656.704, 656.726(4); Stats. Implemented: ORS 656.704
Hist: Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0010 Medical Billing and Payment

(1) **General.**

(a) Only treatment that falls within the scope and field of the medical provider's license to practice will be paid under a workers' compensation claim.

Except for emergency services or as otherwise provided for by statute or these rules, treatments and medical services are only payable if approved by the worker's attending physician or authorized nurse practitioner. Fees for services by more than one physician at the same time are payable only when the services are sufficiently different that separate medical skills are needed for proper care.

(b) All billings must include the patient's full name, date of injury, and the employer's name. If available, billings must also include the insurer's claim number and the provider's NPI. If the provider does not have an NPI, then the provider must provide its license number and the billing provider's FEIN. For provider types not licensed by the state, "99999" must be used in place of the state license number. Bills must not contain a combination of ICD-9 and ICD-10 codes.

(c) The medical provider must bill their usual fee charged to the general public. The submission of the bill by the medical provider is a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The director may require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public. For purposes of this rule, "general public" means any person who receives medical services, except those persons who receive medical services subject to specific billing arrangements allowed under the law that require providers to bill other than their usual fee.

(d) Medical providers must not submit false or fraudulent billings, including billing for services not provided. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. A request for pre-payment for a deposition is not considered false or fraudulent.

(e) When a provider treats a patient with two or more compensable claims, the provider must bill individual medical services for each claim separately.

(f) When rebilling, medical providers must indicate that the charges have been previously billed.

(g) If a patient requests copies of medical bills in writing, medical providers must provide copies within 30 days of the request, and provide any copies of future bills during the regular billing cycle.

(2) **Billing Timelines.** (For payment timelines see OAR 436-009-0030.)

(a) Medical providers must bill within:

(A) 60 days of the date of service;

(B) 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or

(C) 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer.

(b) If the provider bills past the timelines outlined in subsection (a) of this section, the provider may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.

(c) When submitting a bill later than outlined in subsection (a) of this section, a medical provider must establish good cause. Good cause may include, but is not limited to, such issues as extenuating circumstances or circumstances considered outside the control of the provider.

(d) When a provider submits a bill within 12 months of the date of service, the insurer may not reduce payment due to late billing.

(e) When a provider submits a bill more than 12 months after the date of service, the bill is not payable, except when a provision of subsection (2)(a) is the reason the billing was submitted after 12 months.

(3) **Billing Forms.**

(a) All medical providers must submit bills to the insurer unless a contract directs the provider to bill the managed care organization (MCO).

(b) Medical providers must submit bills on a completed current UB-04 (CMS 1450) or

CMS 1500 except for:

(A) Dental billings, which must be submitted on American Dental Association dental claim forms;

(B) Pharmacy billings, which must be submitted on a current National Council for Prescription Drug Programs (NCPDP) form; or

(C) Electronic billing transmissions of medical bills (see OAR 436-008).

(c) Notwithstanding subsection (3)(b) of this rule, a medical service provider doing an IME may submit a bill in the form or format agreed to by the insurer and medical service provider.

(d) Medical providers may use computer-generated reproductions of the appropriate forms.

(e) Unless different instructions are provided in the table below, the provider should use the instructions provided in the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual.

Box Reference Number	Instruction
10d	May be left blank
11a, 11b, and 11c	May be left blank
17a	May be left blank if box 17b contains the referring provider's NPI
21	For dates of service prior to Oct. 1, 2015, use ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, use ICD-10-CM codes.
22	May be left blank
23	May be left blank
24D	The provider must use the following codes to accurately describe the services rendered: • CPT® codes listed in CPT® 2016; • Oregon Specific Codes (OSCs); or • HCPCS codes, only if there is no specific CPT® or OSC. If there is no specific code for the medical service: • The provider should use an appropriate unlisted code from CPT® 2016 (e.g., CPT® code 21299) or an unlisted code from HCPCS (e.g., HCPCS code E1399); and • The provider should describe the service provided. Nurse practitioners and physician assistants must use modifier "81" when billing as the surgical assistant during surgery.
24I (shaded area)	See under box 24J shaded area.
24J (non-shaded area)	The rendering provider's NPI.
24J (shaded area)	If the bill includes the rendering provider's NPI in the non-shaded area of box 24J, the shaded area of box 24I and 24J may be left blank. If the rendering provider does not have an NPI, then include the rendering provider's state license number and use the qualifier "0B" in box 24I.
32	If the facility name and address are different than the billing provider's name and address in box 33, fill in box 32.
32a	If there is a name and address in box 32, box 32a must be filled in even if the NPI is the same as box 33a.

(4) **Billing Codes.**

(a) When billing for medical services, a medical provider must use codes listed in CPT® 2016 or Oregon specific codes (OSC) listed in OAR 436-009-0060 that accurately describe the service. If there is no specific CPT® code or OSC, a medical provider must use the appropriate HCPCS or dental code, if available, to identify the medical supply or service. If there is no specific code for the medical service, the medical provider must use the unlisted code at the end of each medical service section of CPT® 2016 or the appropriate unlisted HCPCS code, and provide a description of the service provided.

A medical provider must include the National Drug Code (NDC) to identify the drug or biological when billing for pharmaceuticals.

(b) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.

(5) **Modifiers.**

(a) When billing, unless otherwise provided by these rules, medical providers must use the appropriate modifiers found in CPT® 2016, HCPCS' level II national modifiers, or anesthesia modifiers, when applicable.

(b) Modifier 22 identifies a service provided by a medical service provider that requires significantly greater effort than typically required. Modifier 22 may only be reported with surgical procedure codes with a global period of 0, 10, or 90 days as listed in Appendix B. The bill must include documentation describing the additional work. It is not sufficient to simply document the extent of the patient's comorbid condition that caused the additional work. When a medical service provider appropriately bills for an eligible procedure with modifier 22, the payment rate is 125% of the fee published in Appendix B, or the fee billed, whichever is less. For all services identified by modifier 22, two or more of the following factors must be present:

(A) Unusually lengthy procedure;

(B) Excessive blood loss during the procedure;

(C) Presence of an excessively large surgical specimen (especially in abdominal surgery);

(D) Trauma extensive enough to complicate the procedure and not billed as separate procedure codes;

(E) Other pathologies, tumors, malformations (genetic, traumatic, or surgical) that directly interfere with the procedure but are not billed as separate procedure codes; or

(F) The services rendered are significantly more complex than described for the submitted CPT®.

(6) **Physician Assistants and Nurse Practitioners.**

Physician assistants and nurse practitioners must document in the chart notes that they provided the medical service. If physician assistants or nurse practitioners provide services as surgical assistants during surgery, they must bill using modifier "81."

(7) **Chart Notes.**

(a) All original medical provider billings must be accompanied by legible chart notes. The chart notes must document the services that have been billed and identify the person performing the service.

(b) Chart notes must not be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(c) When processing electronic bills, the insurer may waive the requirement that bills be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. Medical providers may submit their chart notes separately or at regular intervals as agreed with the insurer.

(8) **Challenging the Provider's Bill.**

For services where the fee schedule does not establish a fixed dollar amount, an insurer may challenge the reasonableness of a provider's bill on a case by case basis by asking the director to review the bill under OAR 436-009-0008. If the director determines the amount billed is unreasonable, the director may establish a different fee to be paid to the provider based on at least one of, but not limited to, the following: reasonableness, the usual fees of similar providers, fees for similar services in similar geographic regions, or any extenuating circumstances.

(9) **Billing the Patient / Patient Liability.**

(a) A patient is not liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer according to OAR chapter 436. However, the patient may be liable, and the provider may bill the patient:

(A) If the patient seeks treatment for conditions not related to the accepted compensable injury or illness;

(B) If the patient seeks treatment for a service that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but is not limited to, ongoing treatment by non-attending physicians in excess of the 30-day/12-visit period or by nurse practitioners in excess of the 180-day period, as set forth in ORS 656.245 and OAR 436-010-0210;

(C) If the insurer notifies the patient that he or she is medically stationary and the patient seeks palliative care that is not authorized by the insurer or the director under OAR 436-010-0290;

(D) If an MCO-enrolled patient seeks treatment from the provider outside the provisions of a governing MCO contract; or

(E) If the patient seeks treatment listed in section (12) of this rule after the patient has been notified that such treatment is unscientific, unproven, outmoded, or experimental.

(b) If the director issues an order declaring an already rendered medical service or treatment inappropriate, or

otherwise in violation of the statute or administrative rules, the worker is not liable for such services.

(10) **Disputed Claim Settlement (DCS).**

The insurer must pay a medical provider for any bill related to the claimed condition received by the insurer on or before the date the terms of a DCS were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS, except, if the DCS payments have already been made, the payment must not be deducted from the settlement proceeds. Payment must be made within 45 days of the insurer's knowledge of the outstanding bill.

(11) **Payment Limitations.**

(a) Insurers do not have to pay providers for the following:

(A) Completing forms 827 and 4909;

(B) Providing chart notes with the original bill;

(C) Preparing a written treatment plan;

(D) Supplying progress notes that document the services billed;

(E) Completing a work release form or completion of a PCE form, when no tests are performed;

(F) A missed appointment "no show" (see exceptions below under section (13) Missed Appointment "No Show"); or

(G) More than three mechanical muscle testing sessions per treatment program or when not prescribed and approved by the attending physician or authorized nurse practitioner.

(b) Mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient. Additional mechanical muscle testing may be paid for only when authorized in writing by the insurer prior to the testing.

(c) Dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the patient.

(d) Vitamin B-12 injections are not reimbursable unless necessary for a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.

(12) **Excluded Treatment.**

The following medical treatments (or treatment of side effects) are not compensable and insurers do not have to pay for:

(a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;

(b) Intradiscal electrothermal therapy (IDET);

(c) Surface electromyography (EMG) tests;

(d) Rolfing;

(e) Prolotherapy;

(f) Thermography;

(g) Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:

(A) The single level artificial disc replacement is between L3 and S1;

(B) The patient is 16 to 60 years old;

(C) The patient underwent a minimum of six months unsuccessful exercise based rehabilitation; and

(D) The procedure is not found inappropriate under OAR 436-010-0230;

(h) Cervical artificial disc replacement, unless it is a single level replacement with a semi-constrained metal on polymer or a semi-constrained metal on metal device and:

(A) The single level artificial disc replacement is between C3 and C7;

(B) The patient is 16 to 60 years old;

(C) The patient underwent unsuccessful conservative treatment;

(D) There is intraoperative visualization of the surgical implant level; and

(E) The procedure is not found inappropriate under OAR 436-010-0230; and

(i) Platelet rich plasma (PRP) injections.

(13) **Missed Appointment (No Show).**

In general, the insurer does not have to pay for "no show" appointments. However, insurers must pay for "no show" appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams. If the patient does not give 48 hours notice, the insurer must pay the provider 50 percent of the exam or testing fee and 100 percent for any review of the file that was completed prior to cancellation or missed appointment.

Stat. Auth.: ORS 656.245, 656.252, 656.254; Stats. Implemented: ORS 656.245, 656.252, 656.254
Hist: Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0018 Discounts and Contracts

(1) **Medical Service Providers and Medical Clinics.**

For the purpose of this rule:

(a) "Medical Service Provider" means a person duly licensed to practice one or more of the healing arts.

(b)"Clinic" means a group practice in which several medical service providers work cooperatively.

(2) **Discounts.**

(a) An insurer may only apply the following discounts to a medical service provider's or clinic's fee:

(A) A fee agreed to under a fee discount agreement that conforms to this rule and has been reported to the director; or

(B) A fee agreed to by the medical service provider or clinic under an MCO contract to cover services provided to a worker enrolled in the MCO.

(b) If the insurer has multiple contracts with a medical service provider or clinic, and one of the contracts is through an MCO for services provided to an enrolled worker, the insurer may only apply the discount under the MCO's contract.

(c) Any discount under a fee discount agreement cannot be more than 10 percent of the fee schedule amount.

(d) An insurer may not apply a fee discount until the medical service provider or clinic and the insurer have signed the fee discount agreement.

(3) **Fee Discount Agreements.**

(a) The fee discount agreement between the parties must be on the provider's letterhead and contain all the information listed on Form 3659. Bulletin 352 provides further information. The agreement must include the following:

(A) A statement that the medical service provider or clinic understands and voluntarily agrees with the terms of the fee discount agreement;

(B) The effective and end dates of the agreement;

(C) The discount rate or rates under the agreement;

(D) A statement that the insurer or employer may not direct patients to the provider or clinic, and that the insurer or employer may not direct or manage the care a patient receives;

(E) A statement that the agreement only applies to patients who are being treated for Oregon workers' compensation claims;

(F) A statement that the fee discount agreement may not be amended. A new fee discount agreement must be executed to change the terms between the parties;

(G) A statement that either party may terminate the agreement by providing the other party with 30 days written notice;

(H) The name and address of the singular insurer or self-insured employer that will apply the discounts;

(I) The national provider identifier (NPI) for the provider or clinic; and

(J) Other terms and conditions to which the medical service provider or clinic and the insurer agree and that are consistent with these rules.

(b) Once the fee discount agreement has been signed by the insurer and medical service provider or clinic, the insurer must report the fee discount agreement to the director by completing the director's online form. The following information must be included:

(A) The insurer's name that will apply the discounts under the fee discount agreement;

(B) The medical service provider's or clinic's name;

(C) The effective date of the agreement;

(D) The end date of the agreement;

(E) The discount rate under the agreement; and

(F) An indication that all the terms required under section (3)(a) of this rule are included in the signed fee discount agreement.

(4) **Fee Discount Agreement Modifications and Terminations.**

(a) When the medical service provider or clinic and the insurer agree to modify an existing fee discount agreement, the parties must enter into a new fee discount agreement.

(b) Either party to the fee discount agreement may terminate the agreement by providing 30 days written notice to the other party. The insurer must report the termination to the director prior to the termination taking effect by completing the director's online form. The following information must be reported:

(A) The insurer's name;

(B) The medical service provider's or clinic's name; and

(C) The termination date of the agreement.

(5) Other Medical Providers.

(a) For the purpose of this rule, "other medical providers" means providers such as hospitals, ambulatory surgery centers, or vendors of medical services and does not include medical service providers or clinics.

(b) The insurer may apply a discount to the medical provider's fee if a written or verbal contract exists.

(c) If the insurer and the medical provider have multiple contracts, only one discount may be applied.

(d) If the insurer has multiple contracts with a provider and one of the contracts is through an MCO for services provided to an enrolled worker, the insurer may only apply the discount under the MCO's contract.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Amended 3/12/15 as Admin Order 15-058, eff. 4/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0020 Hospitals

(1) **Inpatient.**

(a) For the purposes of this rule, hospital inpatient services are those services that are billed with codes "0111" through "0118" in form locator #4 on the UB-04 billing form.

(b) Hospital inpatient bills must include:

(A) For dates of service prior to Oct. 1, 2015, ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, ICD-10-CM codes;

(B) When applicable, procedural codes;

(C) The hospital's NPI; and

(D) The Medicare Severity Diagnosis Related Group (MS-DRG) code, except for:

(i) Bills from critical access hospitals, (See Bulletin 290); or

(ii) Bills containing revenue code 002x.

(c) Unless otherwise provided by contract, the insurer must pay the audited bill for hospital inpatient services by multiplying the amount charged by the hospital's adjusted cost-to-charge ratio (See Bulletin 290). The insurer must pay in-state hospitals not listed in Bulletin 290 at 80 percent of billed charges for inpatient services.

(2) **Outpatient.**

(a) For the purposes of this rule, hospital outpatient services are those services that are billed with codes "0131" through "0138" in form locator #4 on the UB-04 billing form.

(b) Hospital outpatient bills must, when applicable, include the following:

(A) Revenue codes;

(B) For dates of service prior to Oct. 1, 2015, ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, ICD-10-CM codes,

(C) CPT® codes and HCPCS codes; and

(D) The hospital's NPI.

(c) Unless otherwise provided by contract, the insurer must pay for hospital outpatient services as follows:

Revenue Code	Pay Amount:	
0320-0359 0400-0409 0420-0449 0610-0619	Lesser of:	Non-facility column in Appendix B or
		The amount billed
0960-0989	Lesser of:	Facility column in Appendix B or
		The amount billed
All other revenue codes	• For hospitals listed in Bulletin 290, the amount billed multiplied by the cost-to-charge ratio. • For in-state hospitals not listed in Bulletin 290, 80% of the amount billed. • For out-of-state hospitals, the amount billed multiplied by a cost-to-charge ratio of 1.000.	

(3) **Specific Circumstances.**

When a patient is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission are considered part of the inpatient treatment. Diagnostic testing done prior to inpatient treatment is considered part of the hospital services subject to the hospital inpatient fee schedule.

(4) **Out-of-State Hospitals.**

(a) The payment to out-of-state hospitals may be negotiated between the insurer and the hospital.

(b) Any agreement for payment less than the billed amount must be in writing and signed by the hospital and insurer representative.

(c) The agreement must include language that the hospital will not bill the patient any remaining balance and that the negotiated amount is considered payment in full.

(d) If the insurer and the hospital are unable to reach an agreement within 45 days of the insurer's receipt of the bill, either party may bring the issue to the director for resolution. The director may order payment up to the amount billed considering factors such as, but not limited to, reasonableness, usual fees for similar services by facilities in similar geographic areas, case specific services, and any extenuating circumstances.

(5) **Calculation of Cost-to-Charge Ratio Published in Bulletin 290.**

(a) Each hospital's CMS 2552 form and financial statement is the basis for determining its adjusted cost-to-charge ratio. If a current form 2552 is not available, then financial statements may be used to develop estimated data. If the adjusted cost–to-charge ratio is determined from estimated data, the hospital will receive the lower ratio of either the hospital's last published cost-to-charge ratio or the hospital's cost-to-charge ratio based on estimated data.

(b) The basic cost-to-charge ratio is developed by dividing the total net expenses for allocation shown on Worksheet A, and as modified in subsection (c), by the total patient revenues from Worksheet G-2.

(c) The net expenses for allocation derived from Worksheet A is modified by adding, from Worksheet A-8, the expenses for:

(A) Provider-based physician adjustment;

(B) Patient expenses such as telephone, television, radio service, and other expenses determined by the director to be patient-related expenses; and

(C) Expenses identified as for physician recruitment.

(d) The basic cost-to-charge ratio is further modified to allow a factor for bad debt and the charity care provided by each hospital. The adjustment for bad debt and charity care is calculated in two steps. Step one: Add the dollar amount for net bad debt to the dollar amount for charity care. Divide this sum by the dollar amount of the total patient revenues, from Worksheet G-2, to compute the bad debt and charity ratio. Step two: Multiply the bad debt and charity ratio by the basic cost-to-charge ratio calculated in subsection (5)(b) to obtain the factor for bad debt and charity care.

(e) The basic cost-to-charge ratio is further modified to allow an adequate return on assets. The director will determine a historic real growth rate in the gross fixed assets of Oregon hospitals from the audited financial statements. This real growth rate and the projected growth in a national fixed weight price deflator will be added together to form a growth factor. This growth factor will be multiplied by the total fund balance, from Worksheet G of each hospital's CMS 2552 to produce a fund balance amount. The fund balance amount is then divided by the total patient revenues from Worksheet G-2, to compute the fund balance factor.

(f) The factors resulting from subsections (5)(d) and (5)(e) of this rule are added to the ratio calculated in subsection (5)(b) of this rule to obtain the adjusted cost-to-charge ratio. In no event will the adjusted cost-to-charge ratio exceed 1.00.

(g) The adjusted cost-to-charge ratio for each hospital will be revised annually, at a time based on their fiscal year, as

described by bulletin. Each hospital must submit a copy of its CMS 2552 and financial statements each year within 150 days of the end of the hospital's fiscal year to the Information Technology and Research Section, Department of Consumer and Business Services. The adjusted cost-to-charge ratio schedule will be published by bulletin twice yearly, effective for the six-month period beginning April 1 and the six-month period beginning October 1.

(h) For newly formed or established hospitals for which no CMS 2552 has been filed or for which there is insufficient data, or for those hospitals that do not file Worksheet G-2 with the submission of their CMS 2552, the division determines an adjusted cost–to-charge ratio for the hospital based upon the adjusted cost to charge ratios of a group of hospitals of similar size or geographic location.

(i) If the financial circumstances of a hospital unexpectedly or dramatically change, the division may revise the hospital's adjusted cost-to-charge ratio to allow equitable payment.

(j) If audit of a hospital's CMS 2552 by the CMS produces significantly different data from that obtained from the initial filing, the division may revise the hospital's adjusted cost-to-charge ratio to reflect the data developed subsequent to the initial calculation.

(k) Notwithstanding subsections (1)(c) and (2)(c) of this rule, the director may exclude rural hospitals from imposition of the adjusted cost-to-charge ratio based upon a determination of economic necessity. The rural hospital exclusion will be based on the financial health of the hospital reflected by its financial flexibility index. All rural hospitals having a financial flexibility index at or below the median for critical access hospitals nationwide qualify for the rural exemption. Rural hospitals that are designated as critical access hospitals under the Oregon Medicare Rural Hospital Flexibility Program are automatically exempt from imposition of the adjusted cost-to-charge ratio.

Stat. Auth.: Stat. Auth.: ORS 656.726(4), also see 656.012, 656.236(5), 656.327(2), 656.313(4)(d)
Stats. Implemented: ORS 656.248; 656.252; 656.256
Hist: Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0023 Ambulatory Surgery Center (ASC)

(1) **Billing Form.**

(a) The ASC must submit bills on a completed, current CMS 1500 form (see OAR 436-009-0010 (3)) unless the ASC submits medical bills electronically. Computer-generated reproductions of the CMS 1500 form may also be used.

(b) The ASC must add a modifier "SG" in box 24D of the CMS 1500 form to identify the facility charges.

(2) **ASC Facility Fee.**

(a) The following services are included in the ASC facility fee and the ASC may not receive separate payment for them:

(A) Nursing, technical, and related services;

(B) Use of the facility where the surgical procedure is performed;

(C) Drugs and biologicals designated as packaged in Appendix D, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure;

(D) Radiology services designated as packaged in Appendix D;

(E) Administrative, record-keeping, and housekeeping items and services;

(F) Materials for anesthesia;

(G) Supervision of the services of an anesthetist by the operating surgeon; and

(H) Packaged services identified in Appendix C or D.

(b) The payment for the surgical procedure (i.e., the ASC facility fee) does not include physician's services, laboratory, X-ray, or diagnostic procedures not directly related to the surgical procedures, prosthetic devices, orthotic devices, durable medical equipment (DME), or anesthetists' services.

(3) **ASC Billing.**

(a) The ASC should not bill for packaged codes as separate line-item charges when the payment amount says "packaged" in Appendices C or D.

(b) When the ASC provides packaged services (see Appendices C and D) with a surgical procedure, the billed amount should include the charges for the packaged services.

(c) For the purpose of this rule, an implant is an object or material inserted or grafted into the body. When the ASC's cost for an implant is $100 or more, the ASC may bill for the implant as a separate line item. The ASC must provide the insurer a receipt of sale showing the ASC's cost of the implant.

(4) **ASC Payment.**

(a) Unless otherwise provided by contract, insurers must pay ASCs for services according to this rule.

(b) Insurers must pay for surgical procedures (i.e., ASC facility fee) and ancillary services the lesser of:

(A) The maximum allowable payment amount for the HCPCS code found in Appendix C for surgical procedures, and in Appendix D for ancillary services integral to a surgical procedure; or

(B) The ASC's usual fee for surgical procedures and ancillary services.

(c) When more than one procedure is performed in a single operative session, insurers must pay the principal procedure at 100 percent of the maximum allowable fee, and the secondary and all subsequent procedures at 50 percent of the maximum allowable fee.

A diagnostic arthroscopic procedure performed preliminary to an open operation is considered a secondary procedure and should be paid accordingly.

The multiple surgery discount described in this section does not apply to codes listed in Appendix C with an "N" in the "Subject to Multiple Procedure Discounting" column.

(d) The table below lists packaged surgical codes that ASCs may perform without any other surgical procedure. In this case do not use Appendix C to calculate payment, use the rates listed below instead.

CPT® Code	Maximum Payment Amount		CPT® Code	Maximum Payment Amount
23350	$235.12		36410	$19.94
25246	$220.99		36416	80% of billed
27093	$304.90		36620	80% of billed
27370	$290.78		62284	$282.47
27648	$274.16		62290	$417.89
36000	$39.05			

(e) When the ASC's cost of an implant is more than $100, insurers must pay for the implants at 110 percent of the ASC's actual cost documented on a receipt of sale and not according to Appendix D or E.

(f) When the ASC's cost of an implant is less than $100, insurers are not required to pay separately for the implant.

An implant may consist of several separately billable components, some of which may cost less than $100. For payment purposes, insurers must add the costs of all the components for the entire implant and use that total amount to calculate payment for the implant.

(g) The insurer does not have to pay the ASC when the ASC provides services to a patient who is enrolled in a managed care organization (MCO) and:

(A) The ASC is not a contracted facility for the MCO;

(B) The MCO has not pre-certified the service provided; or

(C) The surgeon is not an MCO panel provider.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245; 656.248; 656.252
Hist: Amended 3/12/15 as Admin Order 15-058, eff. 4/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0025 Worker Reimbursement

(1) **General.**

(a) When the insurer accepts the claim the insurer must notify the worker in writing that:

(A) The insurer will reimburse claim-related services paid by the worker; and

(B) The worker has two years to request reimbursement.

(b) The worker must request reimbursement from the insurer in writing. The insurer may require reasonable documentation such as a sales slip, receipt, or other evidence to support the request. The worker may use Form 3921 – Request for Reimbursement of Expenses.http://wcd.oregon.gov/wcdforms/3921.doc

(c) Insurers must date stamp requests for reimbursement on the date received.

(d) The insurer or its representative must provide a written explanation to the worker for each type of out-of-pocket expense (mileage, lodging, medication, etc.) being paid or denied.

(e) The explanation to the worker must be in 10 point size font or larger and must include:

(A) The amount of reimbursement for each type of out-of-pocket expense requested.

(B) The specific reason for non-payment, reduced payment, or discounted payment for each itemized out-of-pocket expense the worker submitted for reimbursement;

(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a worker's reimbursement question within two days, excluding weekends and legal holidays;

(D) The following notice, Web link, and phone number:

"To access Bulletin 112 with information about reimbursement amounts for travel, food, and lodging costs visit www.oregonwcdoc.info or

call 503-947-7606.";

(E) Space for the worker's signature and date; and

(F) A notice of right to administrative review as follows:

"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."

(f) According to ORS 656.325(1)(f) and OAR 436-060-0095(5)(f), when a worker attends an independent medical examination (IME), the insurer must reimburse the worker for related costs regardless of claim acceptance, deferral, or denial.

(2) **Timeframes.**

(a) The worker must submit a request for reimbursement of claim-related costs by whichever date is later:

(A) Two years from the date the costs were incurred or

(B) Two years from the date the claim or medical condition is finally determined compensable.

(b) If the worker requests reimbursement after two years as listed in subsection (a), the insurer may disapprove the reimbursement request.

(c) On accepted claims the insurer must, within 30 days of receiving the reimbursement request:

(A) Reimburse the worker if the request shows the costs are related to the accepted claim;

(B) Disapprove the request if unreasonable or if the costs are not related to the accepted claim; or

(C) Request additional information from the worker to determine if costs are related to the accepted claim. If additional information is needed, the time needed to obtain the information is not counted in the 30-day time frame for the insurer to issue reimbursement.

(d) When the insurer receives a reimbursement request before claim acceptance, and the claim is ultimately accepted, by whichever date is later the insurer must:

(A) Within 30 days of receiving the reimbursement request:

(i) Reimburse the worker if the request shows the costs are related,

(ii) Disapprove the request if unreasonable or if the costs are not related, or

(iii) Request additional information. If additional information is needed, the time needed to obtain the information is not counted in the 30-day time frame for the insurer to issue reimbursement; or

(B) Within 14 days of claim acceptance:

(i) Reimburse the worker if the request shows the costs are related,

(ii) Disapprove the request if unreasonable or if the costs are not related, or

(iii) Request additional information. If additional information is needed, the time needed to obtain the information is not counted in the 14-day time frame for the insurer to issue reimbursement.

(e) In a claim for aggravation or a new medical condition, reimbursement requests are not due and payable until the aggravation or new medical condition is accepted.

(f) If the claim is denied, requests for reimbursement must be returned to the worker within 14 days, and the insurer must retain a copy.

(3) **Meal and Lodging Reimbursement.**

(a) Meal reimbursement is based on whether a meal is reasonably required by necessary travel to a claim-related appointment.

(b) Lodging reimbursement is based on the need for an overnight stay to attend an appointment.

(c) Meals and lodging are reimbursed at the actual cost or the rate published in Bulletin 112, whichever is less. Lodging reimbursement may exceed the maximum rate published in Bulletin 112 when special lodging is required or when the worker is unable to find lodging at or below the maximum rate within 10 miles of the appointment location.

(4) **Travel Reimbursement.**

(a) Insurers must reimburse workers for actual and reasonable costs for travel to medical providers paid by the worker under ORS 656.245(1)(e), 656.325, and 656.327.

(b) The insurer may limit worker reimbursement for travel to an attending physician if the insurer provides a prior written explanation and a written list of attending physicians that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker.

The insurer may limit worker reimbursement for travel to an authorized nurse practitioner if the insurer provides a prior written explanation and a written list of authorized nurse practitioners that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker.

The insurer must inform the worker that he or she may continue treating with the established attending physician or authorized nurse practitioner; however, reimbursement of transportation costs may be limited to the distance from the worker's home to a provider on the written list.

(c) Within a metropolitan area the insurer may not limit worker reimbursement for travel to an attending physician or authorized nurse practitioner even if there are medical providers closer to the worker.

(d) Travel reimbursement dispute decisions will be based on principles of reasonableness and fairness within the context of the specific case circumstances as well as the spirit and intent of the law.

(e) Personal vehicle mileage is the reasonable actual distance based on the beginning and ending addresses. The mileage reimbursement is limited to the rate published in Bulletin 112.

(f) Public transportation or, if required, special transportation will be reimbursed based on actual cost.

(5) **Other Reimbursements.**

(a) The insurer must reimburse the worker for other claim-related expenses based on actual cost. However, reimbursement for hearing aids is limited to the amounts listed in OAR 436-009-0080.

(b) For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515.

When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must either pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy. The worker may then request reimbursement from the insurer. However, if the insurer has previously notified the worker in writing that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug.

(c) For IMEs, child care costs are reimbursed at the rate prescribed by the State of Oregon Department of Human Services.

(d) Home health care provided by a worker's family member is not required to be under the direct control and supervision of the attending physician. A worker may receive reimbursement

for such home health care services only if the family member demonstrates competency to the satisfaction of the worker's attending physician.

(6) **Advancement Request.**

If necessary to attend a medical appointment, the worker may request an advance for transportation and lodging expenses. Such a request must be made to the insurer in sufficient time to allow the insurer to process the request.

Stat. Auth.: ORS 656.245, 656.325, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.245, 656.704, and 656.726(4)
Hist: Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0030 Insurer's Duties and Responsibilities

(1) **General.**

(a) The insurer must pay for medical services related to a compensable injury claim, except as provided by OAR 436-060-0055.

(b) The insurer, or its designated agent, may request from the medical provider any and all necessary records needed to review accuracy of billings. The medical provider may charge an appropriate fee for copying documents under OAR 436-009-0060. If the evaluation of the records must be conducted on-site, the provider must furnish a reasonable work-site for the records to be reviewed at no cost. These records must be provided or made available for review within 14 days of a request.

(c) The insurer must establish an audit program for bills for all medical services to determine that the bill reflects the services provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum fees adopted by the director, and that bills are submitted in a timely manner. The audit must be continuous and must include no fewer than 10 percent of medical bills.

The insurer must provide upon the director's request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation must include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.

(2) **Bill Processing.**

(a) Insurers must date stamp medical bills, chart notes, and other documentation upon receipt. Bills not submitted according to OAR 436-009-0010(1)(b) and (2) must be returned to the medical provider within 20 days of receipt of the bill with a written explanation describing why the bill was returned and what needs to be corrected. A request for chart notes on EDI billings must be made to the medical provider within 20 days of the receipt of the bill.

The number of days between the date the insurer returns the bill or requests chart notes and the date the insurer receives the corrected bill or chart notes, does not count toward the 45 days within which the insurer is required to make payment.

(b) The insurer must retain a copy of each medical provider's bill received by the insurer or must be able to reproduce upon request data relevant to the bill, including but not limited to, provider name, date of service, date the insurer received the bill, type of service, billed amount, coding submitted by the medical provider as described in OAR 436-009-0010(1)(b) and (3)(b), and insurer action, for any non-payment or fee reduction. This includes all bills submitted to the insurer even when the insurer determines no payment is due.

(c) Any service billed with a code number commanding a higher fee than the services provided must be returned to the medical provider for correction or paid at the value of the service provided.

(3) **Payment Requirements.**

(a) Insurers must pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the bill is submitted in proper form according to OAR 436-009-0010(1)(b), (3)(a) through (7)(c), and clearly shows that the treatment is related to the accepted compensable injury or disease.

(b) The insurer or its representative must provide a written explanation of benefits (EOB) of the services being paid or denied. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. The insurer or its representative must send the explanation to the medical provider that billed for the services. For the purpose of this rule an EOB has the same meaning as an explanation of review (EOR).

(c) The written EOB must be in 10 point size font or larger. Electronic and written explanations must include:

(A) The amount of payment for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;

(B) The specific reason for non-payment, reduced payment, or discounted payment for each service billed;

(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a medical provider's payment question within two days, excluding weekends and legal holidays;

(D) The following notice, Web link, and phone number:

"To access information about Oregon's Medical Fee and Payment Rules, visit

www.oregonwcdoc.info or call 503-947-7606.";

(E) Space for the provider's signature and date; and

(F) A notice of right to administrative review as follows:

"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document

with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."

(d) Payment of medical bills is required within 14 days of any action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later.

(e) Failure to pay for medical services timely may render the insurer liable to pay a reasonable monthly service charge for the period payment was delayed, if the provider customarily applies such a service charge to the general public.

(f) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each medical service code.

(g) Bills for medical services rendered at the request of the insurer and bills for information submitted at the request of the insurer, which are in addition to those required in OAR 436-010-0240 must be paid within 45 days of receipt by the insurer even if the claim is denied.

(h) If an insurer determines that it has made an overpayment to a provider for medical services, the insurer may request a refund from the provider. The insurer must make the request within 180 days of the payment date. Resolution of overpayment disputes must be made under OAR 436-009-0008.

(4) **Communication with Providers.**

(a) The insurer or its representative must respond to a medical provider's inquiry about a medical payment within two days, not including weekends or legal holidays. The insurer or its representative may not refer the medical provider to another entity to obtain an answer.

(b) An insurer or its representative and a medical provider may agree to send and receive payment information by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 to 646A.628 and federal law.

(5**) EDI Reporting.**

For medical bill reporting requirements, see OAR 436-160 Electronic Data Interchange Medical Bill Data rules.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0035 Interim Medical Benefits

(1) **General.**

(a) Interim medical benefits under ORS 656.247 only apply to initial claims when the patient has a health benefit plan, i.e., the patient's private health insurance. For the purpose of this rule the Oregon Health Plan is not a health benefit plan.

(b) Interim medical benefits are not due on claims:

(A) When the patient is enrolled in an MCO prior to claim acceptance or denial under ORS 656.245(4)(b)(B); or

(B) When the insurer denies the claim within 14 days of the employer's notice of the claim.

(c) Interim medical benefits cover services provided from the date of employer's notice or knowledge of the claim to the date the insurer accepts or denies the claim. Interim medical benefits do not include treatments excluded under OAR 436-009-0010(12).

(d) When billing for interim medical benefits, the medical provider must bill the workers' compensation insurer according to these rules, and the health benefit plan according to the plan's requirements. The provider may submit a pre-authorization request to the health benefit plan prior to claim acceptance or denial.

(e) If the medical provider knows that the patient filed a work-related claim, the medical provider may not collect any health benefit plan co-pay, co-insurance, or deductible from the patient during the interim period.

(2) **Claim Acceptance.**

If the insurer accepts the claim:

(a) The insurer must pay medical providers for services according to these rules; and

(b) The provider, after receiving payment from the insurer, must reimburse the worker and the health benefit plan for any medical expenses, co-pays, co-insurance, or deductibles, paid by the worker or the health benefit plan.

(3) **Claim Denial.**

If the insurer denies the claim:

(a) The insurer must notify the medical provider as provided in OAR 436-060-0140 that an initial claim has been denied; and

(b) The medical provider must bill the health benefit plan, unless the medical provider has previously billed the health benefit plan. The provider must forward a copy of the workers' compensation denial letter to the health benefit plan.

Stat. Auth: ORS 656.245, 656.704, and 656.726(4)
Stat. Implemented: ORS 656.247
Hist: Amended 3/12/15 as Admin Order 15-058, eff. 4/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0040 Fee Schedule

(1) Fee Schedule Table.

(a) Unless otherwise provided by contract or fee discount agreement allowed by these rules, insurers must pay according to the following table:

Services	Codes	Payment Amount:	
Services billed with **CPT®** codes, **HCPCS** codes, or Oregon Specific Codes (**OSC**):	Listed in Appendix B and performed in medical service provider's office	Lesser of:	Amount in non-facility column in Appendix B, or
			Provider's usual fee
	Listed in Appendix B and **not** performed in medical service provider's office	Lesser of:	Amount in facility column in Appendix B*, or
			Provider's usual fee
Dental Services billed with dental procedure codes:	D0000 through D9999	90% of provider's usual fee	
Ambulance Services billed with HCPCS codes:	A0425, A0426, A0427, A0428, A0429, A0433, and A0434	100% of provider's usual fee	
Services billed with **HCPCS** codes:	Not listed in the fee schedule	80% of provider's usual fee	
Services not described above:		80% of provider's usual fee	
* However, for all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the Non-Facility Maximum column.			

(b) The global period is listed in the column 'Global Days' of Appendix B.

(2) Anesthesia.

(a) When using the American Society of Anesthesiologists Relative Value Guide, a basic unit value is determined by reference to the appropriate anesthesia code. The total anesthesia value is made up of a basic unit value and, when applicable, time and modifying units.

(b) Physicians or certified nurse anesthetists may use basic unit values only when they personally administer the general anesthesia and remain in constant attendance during the procedure for the sole purpose of providing the general anesthesia.

(c) Attending surgeons may not add time units to the basic unit value when administering local or regional block for anesthesia during a procedure. The modifier 'NT' (no time) must be on the bill.

(d) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the payment for the surgical procedure.

(e) In calculating the units of time, use 15 minutes per unit. If a medical provider bills for a portion of 15 minutes, round the time up to the next 15 minutes and pay one unit for the portion of time.

(f) The maximum allowable payment amount for anesthesia codes is determined by multiplying the anesthesia value by a conversion factor of $58.00.

Unless otherwise provided by contract or fee discount agreement permitted by these rules, the insurer must pay the lesser of:

(A) The maximum allowable payment amount for anesthesia codes; or

(B) The provider's usual fee.

(g) When the anesthesia code is designated by IC (individual consideration), unless otherwise provided by a contract or fee discount agreement, the insurer must pay 80 percent of the provider's usual fee.

(3) Surgery.

Unless otherwise provided by contract or fee discount agreement permitted by these rules, insurers must pay multiple surgical procedures performed in the same session according to the following:

(a) One surgeon

Procedures	Appendix B lists:	The payment amount is:	
Principal procedure	A dollar amount	The lesser of:	The amount in Appendix B; or
			The billed amount
	80% of billed amount	80% of billed amount	
Any additional procedures* including: • diagnostic arthroscopy performed prior to open surgery • the second side of a bilateral procedure	A dollar amount	The lesser of:	50% of the amount in Appendix B; or
			The billed amount
	80% of billed amount	40% of the billed amount (unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 80% of the billed amount)	
*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.			

(b) Two or more surgeons

Procedures	Appendix B lists:	The payment amount for each surgeon is:	
Each surgeon performs a principal procedure (and any additional procedures) Any additional procedures including: • diagnostic arthroscopy performed prior to open surgery • the second side of a bilateral procedure	A dollar amount	The lesser of:	75% of the amount in Appendix B for the principal procedures (and 37.5% of the amount in Appendix B for any additional procedures*); or
			The billed amount
	80% of billed amount	60% of the billed amount (and 30% of the billed amount for any additional procedures*) (unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 60% of the billed amount)	
*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.			

(c) Assistant surgeons

Procedures	Appendix B lists:	The payment amount is:	
One or more surgical procedures	A dollar amount	The lesser of:	20% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	20% of the surgeon(s) fee calculated in subsections (a) or (b)	

(d) Nurse practitioners or physician assistants

Procedures	Appendix B lists:	The payment amount is:	
One or more surgical procedures as the primary surgical provider, billed without modifier "81."	A dollar amount	The lesser of:	85% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	85% of the surgeon(s) fee calculated in subsections (a) or (b)	
One or more surgical procedures as the surgical assistant*	A dollar amount	The lesser of:	15% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	15% of the surgeon(s) fee calculated in subsections (a) or (b)	
*Physician assistants and nurse practitioners must mark their bills with a modifier "81." Chart notes must document when medical services have been provided by a physician assistant or nurse practitioner.			

(e) Self-employed surgical assistants who work under the direct control and supervision of a physician

Procedures	Appendix B lists:	The payment amount is:	
One or more surgical procedures	A dollar amount	The lesser of:	10% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	10% of the surgeon(s) fee calculated in subsections (a) or (b)	

(f) When a surgeon performs surgery following severe trauma, and the surgeon does not think the fees should be reduced under the multiple surgery rule, the surgeon may request special consideration by the insurer. The surgeon must provide written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.

(g) If the surgery is non-elective, the physician is entitled to payment for the initial evaluation of the patient in addition to the global fee for the surgical procedure(s) performed. However, the pre-operative visit for elective surgery is included in the listed global value of the surgical procedure, even if the pre-operative visit is more than one day before surgery.

(4) Radiology Services.

(a) Insurers only have to pay for X-ray films of diagnostic quality that include a report of the findings. Insurers will not pay for 14" x 36" lateral views.

(b) When multiple contiguous areas are examined by computerized axial tomography (CAT) scan, computerized tomography angiography (CTA), magnetic resonance angiography (MRA), or magnetic resonance imaging (MRI), then the technical component must be paid 100 percent for the first area examined and 75 percent for all subsequent areas. These reductions do not apply to the professional component.

The reductions apply to multiple studies done within two days, unless the ordering provider provides a reasonable explanation of why the studies needed to be done on separate days.

(5) Pathology and Laboratory Services.

(a) The payment amounts in Appendix B apply only when there is direct physician involvement.

(b) Laboratory fees must be billed in accordance with ORS 676.310. If a physician submits a bill for laboratory services that were performed in an independent laboratory, the bill must show the amount charged by the laboratory and any service fee that the physician charges.

(6) Physical Medicine and Rehabilitation Services.

(a) Time-based CPT® codes must be billed and paid according to this table:

Treatment Time	Bill and Pay As
0 to 7 minutes	0
8 to 22 minutes	1 unit
23 to 37 minutes	2 units
38 to 52 minutes	3 units
53 to 67 minutes	4 units
68 to 82 minutes	5 units

(b) Except for CPT® codes 97001, 97002, 97003, or 97004, payment for modalities and therapeutic procedures is limited to a total of three separate CPT®-coded services per day for each provider, identified by their federal tax ID number. An additional unit of time for the same CPT® code does not count as a separate code.

(c) CPT® codes 97032, 97033, 97034, 97035, 97036, and 97039 are time-based codes and require constant attendance. Chart notes must clearly indicate the time treatment begins and the time treatment ends for the day or the amount of time spent providing the treatment.

(d) CPT® codes 97010 through 97028 are not payable unless they are performed in conjunction with other procedures or modalities that require constant attendance or knowledge and skill of the licensed medical provider.

(e) When multiple treatments are provided simultaneously by one machine, device, or table there must be a notation on the bill that treatments were provided simultaneously by one machine, device, or table and there must be only one charge.

(7) Reports.

(a) Except as otherwise provided in OAR 436-009-0060, when another medical provider, or an insurer or its representative asks a medical provider to prepare a report, or review records or reports, the medical provider should bill the insurer for their report or review of the records using CPT® codes such as 99080. The bill should include documentation of time spent reviewing the records or reports.

(b) If the insurer asks the medical service provider to review the IME report and respond, the medical service provider must bill for the time spent reviewing and responding using OSC D0019. The bill should include documentation of time spent.

(8) Nurse Practitioners and Physician Assistants.

Services provided by authorized nurse practitioners, physician assistants, or out-of-state nurse practitioners must be paid at 85 percent of the amount calculated in section (1) of this rule.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0060 Oregon Specific Code

(1) **Multidisciplinary Services.**

(a) Services provided by multidisciplinary programs not otherwise described by CPT® codes must be billed under Oregon specific codes.

(b) Bills using the multidisciplinary codes must include copies of the treatment record that specifies:

(A) The type of service rendered,

(B) The medical provider who provided the service,

(C) Whether treatment was individualized or provided in a group session, and

(D) The amount of time treatment was rendered for each service billed.

(2) **Table of all Oregon Specific Codes (For OSC fees, see Appendix B.)**

Service	OSC
Arbiter exam - level 1: A basic medical exam with no complicating factors.	AR001
Arbiter exam - level 2: A moderately complex exam that may have complicating factors.	AR002
Arbiter exam - level 3: A very complex exam that may have several complicating factors.	AR003
Arbiter exam – limited: A limited exam that may involve a newly accepted condition, or a partial exam.	AR004
Arbiter file review - level 1: A file review of a limited record.	AR021
Arbiter file review - level 2: A file review of an average record.	AR022
Arbiter file review - level 3: A file review of a large record or a disability evaluation without an exam.	AR023
Arbiter file review - level 4: A file review of an extensive record.	AR024
Arbiter file review - level 5: A file review of an extensive record with unique factors.	AR025
Arbiter report - level 1: A report that answers standard questions.	AR011
Arbiter report - level 2: A report that answers standard questions and complicating factors.	AR012
Arbiter report - level 3: A report that answers standard questions and multiple complicating factors.	AR013
Arbiter report - complex supplemental report: A report to clarify information or to address additional issues.	AR032
Arbiter report - limited supplemental report: A report to clarify information or to address additional issues.	AR031
Closing exam: An exam to measure impairment after the worker's condition is medically stationary.	CE001
Closing report: A report that captures the findings of the closing exam.	CR001
Consultation – attorney: Time spent consulting with an insurer's attorney.	D0001
Consultation – insurer: Time spent consulting with an insurer.	D0030
Copies of medical records: Copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0001
Copies of medical records electronically: Electronic copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0002
Deposition time: Time spent being deposed by insurer's attorney, includes time for preparation, travel, and deposition.	D0002
Director required medical exam or review time: Services by a physician selected under ORS 656.327 or 656.260, to review treatment, perform reasonable and appropriate tests, or examine the worker. Services must be paid at an hourly rate up to 6 hours for record review and exam.	P0001
Director required medical report: Preparation and submission of the report.	P0003
Director required review - complex case fee: Preauthorized fee by the director for an extensive review in a complex case.	P0004

Service	OSC
Director required exam – failure to appear: Patient fails to appear for a director required exam.	P0005
Ergonomic consultation - 1 hour (includes travel): Must be preauthorized by insurer. Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications.	97661
IME (independent medical exam): Report, addendum to a report, file review, or exam.	D0003
IME – review and response: Insurer requested review and response by treating physician; document time spent.	D0019
Interdisciplinary rehabilitation conference - 10 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97655
Interdisciplinary rehabilitation conferences – intermediate - 20 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97656
Interdisciplinary rehabilitation conferences – complex - 30 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97657
Interdisciplinary rehabilitation conferences – complex - each additional 15 minutes - up to 1 hour maximum: Each additional 15 minutes complex conference - up to 1 hour maximum.	97658
Interpreter mileage	D0041
Interpreter services – other than American Sign Language (ASL)	D0004
Interpreter services – American Sign Language (ASL)	D0005

Service	OSC
Job site visit - 1 hour (includes travel): Must be preauthorized by insurer. A work site visit to identify characteristics and physical demands of specific jobs.	97659
Job site visit - each additional 30 minutes	97660
Multidisciplinary conference – initial - up to 30 minutes	97670
Multidisciplinary conference - initial/complex - up to 60 minutes	97671
Narrative – brief: Narrative by the attending physician or authorized nurse practitioner, including a summary of treatment to date and current status and, if requested, brief answers to one to five questions related to the current or proposed treatment.	N0001
Narrative – complex: Narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, treatment to date, current status, impairment, prognosis, and medically stationary information.	N0002
Nursing evaluation - 30 minutes: Nursing assessment of medical status and needs in relationship to rehabilitation.	97664
Nursing evaluation - each additional 15 minutes	97665
Nutrition evaluation - 30 minutes: Evaluation of eating habits, weight, and required modifications in relationship to rehabilitation.	97666
Nutrition evaluation - each additional 15 minutes	97667

Service	OSC
PCE (physical capacity evaluation) - first level: This is a limited evaluation primarily to measure musculoskeletal components of a specific body part. These components include such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level generally requires 30 to 45 minutes of actual patient contact. A first level PCE is paid under OSC 99196, which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99196
PCE - second level: This is a PCE to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish residual functional capacities for claim closure. This level generally requires not less than two hours of actual patient contact. The second level PCE is paid under OSC 99197, which includes the evaluation and report. Additional 15 minute increments may be added to measure additional body parts, to establish endurance and to project tolerances. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99197
PCE – each additional 15 minutes	99193
Physical conditioning - group - 1 hour: Conditioning exercises and activities, graded and progressive.	97642
Physical conditioning - group - each additional 30 minutes	97643
Physical conditioning – individual - 1 hour: Conditioning exercises and activities, graded and progressive.	97644
Physical conditioning – individual - each additional 30 minutes	97645

Service	OSC
Professional case management – individual 15 minutes: Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician).	97654
Social worker evaluation - 30 minutes: Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome.	97668
Social worker evaluation – each additional 15 minutes	97669
Therapeutic education – individual - each additional 30 minutes	97650
Therapeutic education – individual - each additional 15 minutes	97651
Therapeutic education - group 30 minutes: Medical, psychosocial, nutritional, and vocational education dependent on needs and stated goals.	97652
Therapeutic education - group - each additional 15 minutes	97653
Vocational evaluation - 30 minutes: Evaluation of work history, education, and transferable skills coupled with physical limitations in relationship to return-to-work options.	97662
Vocational evaluation - each additional 15 minutes	97663
Physical conditioning - group - 1 hour: Conditioning exercises and activities, graded and progressive.	97642
Physical conditioning - group - each additional 30 minutes	97643

Service	OSC
WCE (work capacity evaluation): This is a residual functional capacity evaluation that generally requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. A WCE is paid under OSC 99198, which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report. Special emphasis should be given to: The ability to perform essential physical functions of the job based on a specific job; Analysis as related to the accepted condition; The ability to sustain activity over time; and The reliability of the evaluation findings.	99198
WCE – each additional 15 minutes	99193
Work simulation - group 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97646
Work simulation - group - each additional 30 minutes	97647
Work simulation - individual 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97648
Work simulation - individual - each additional 30 minutes	97649
WRME (worker requested medical exam): Exam and report.	W0001

(3) **CARF / JCAHO Accredited Programs.**

(a) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program will not be paid unless the program is accredited for that purpose by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

(b) Organizations that have applied for CARF accreditation, but have not yet received accreditation, may receive payment for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. The organizations may provide multidisciplinary services under this section for a period of up to six months from the date CARF provided notice to the organization that the accreditation process has been initiated, or until such time as CARF accreditation has been received or denied, whichever occurs first.

(c) Notwithstanding OAR 436-009-0010(4)(a), program fees for services within a multidisciplinary program may be used based upon written pre-authorization from the insurer. Programs must identify the extent, frequency, and duration of services to be provided.

(d) All job site visits and ergonomic consultations must be preauthorized by the insurer.

Stat. Auth.: ORS 656.726(4) Stats. Implemented: ORS 656.248
Hist: Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0080 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

(1) **Durable medical equipment** (DME), such as Transcutaneous Electrical Nerve Stimulation (TENS), Microcurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc., is equipment that:

(a) Is primarily and customarily used to serve a medical purpose,

(b) Can withstand repeated use,

(c) Could normally be rented and used by successive patients,

(d) Is appropriate for use in the home, and

(e) Is not generally useful to a person in the absence of an illness or injury.

(2) A **prosthetic** is an artificial substitute for a missing body part or any device aiding performance of a natural function. Examples: hearing aids, eye glasses, crutches, wheelchairs, scooters, artificial limbs, etc. The insurer must pay for the repair or replacement of prosthetic appliances damaged as a result of a compensable injury, even if the worker received no other injury. If the appliance is not repairable, the insurer must replace the appliance with a new appliance comparable to the one damaged. If the worker chooses to upgrade the prescribed prosthetic appliance, the worker may do so but must pay the difference in price.

(3) An **orthosis** is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of a moveable body part. Examples: brace, splint, shoe insert or modification, etc.

(4) **Supplies** are materials that may be reused multiple times by the same person, but a single supply is not intended to be used by more than one person, including, but not limited to

incontinent pads, catheters, bandages, elastic stockings, irrigating kits, sheets, and bags.

(5) When billing for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), providers must use the following modifiers, when applicable:

(a) NU for purchased, new equipment

(b) UE for purchased, used equipment

(c) RR for rented equipment

(6) Unless otherwise provided by contract or sections (7) through (11) of this rule, insurers must pay for DMEPOS according to the following table:

If DMEPOS is:	And HCPCS is:	Then payment amount is:	
New	Listed in Appendix E	The lesser of	Amount in Appendix E; or
			Provider's usual fee
	Not listed in Appendix E	80% of provider's usual fee	
Used	Listed in Appendix E	The lesser of	75% of amount in Appendix E; or
			Provider's usual fee
	Not listed in Appendix E	80% of provider's usual fee	
Rented (monthly rate)	Listed in Appendix E	The lesser of	10% of amount in Appendix E; or
			Provider's usual fee
	Not listed in Appendix E	80% of provider's usual fee	

(7) Unless a contract establishes a different rate, the table below lists maximum monthly rental rates for the codes listed (do not use Appendix E or section (6) to determine the rental rates for these codes):

Code	Monthly Rate		Code	Monthly Rate
E0163	$26.33		E0849	$98.40
E0165	$30.24		E0900	$93.68
E0168	$27.28		E0935	$996.97
E0194	$3643.05		E0940	$52.20
E0261	$259.66		E0971	$5.68
E0277	$1135.64		E0990	$25.52
E0434	$35.31		E1800	$262.29
E0441	$86.85		E1815	$276.15
E0650	$1423.50		E2402	$2487.86

(8) For items rented, unless otherwise provided by contract:

(a) The maximum daily rental rate is one thirtieth (1/30) of the monthly rate established in sections (6) and (7) of this rule.

(b) After a rental period of 13 months, the item is considered purchased, if the insurer so chooses.

(c) The insurer may purchase a rental item anytime within the 13-month rental period, with 75 percent of the rental amount paid applied towards the purchase.

(9) For items purchased, unless otherwise provided by contract, the insurer must pay for labor and reasonable expenses at the provider's usual rate for:

(a) Any labor and reasonable expenses directly related to any repairs or modifications subsequent to the initial set-up; or

(b) The provider may offer a service agreement at an additional cost.

(10) **Hearing aids** must be prescribed by the attending physician, authorized nurse practitioner, or specialist physician. Testing must be done by a licensed audiologist or an otolaryngologist.

The preferred types of hearing aids for most patients are programmable behind the ear (BTE), in the ear (ITE), and completely in the canal (CIC) multichannel. Any other types of hearing aids needed for medical conditions will be considered based on justification from the attending physician or authorized nurse practitioner.

Unless otherwise provided by contract, insurers must pay the provider's usual fee for **hearing services** billed with HCPCS codes V5000 through V5999. However, without approval from the insurer or director, the payment for hearing aids may not exceed $7000 for a pair of hearing aids, or $3500 for a single hearing aid. If the worker chooses to upgrade the prescribed hearing aid, the worker may do so but must pay the difference in price.

(11) Unless otherwise provided by contract, insurers must pay the provider's usual fee for **vision services** billed with HCPCS codes V0000 through V2999.

(12) The worker may select the service provider. For claims enrolled in a managed care organization (MCO) the worker may be required to select a provider from a list specified by the MCO.

(13) Except as provided in section (10) of this rule, the payment amounts established by this rule do not apply to a worker's direct purchase of DMEPOS. Workers are entitled to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.

(14) DMEPOS dispensed by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0090 Pharmaceutical

(1) **General.**

(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the patient is medically stationary.

(b) When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. However, a patient may insist on receiving the brand-name drug and either pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy.

(c) Unless otherwise provided by MCO contract, the patient may select the pharmacy.

(2) **Pharmaceutical Billing and Payment.**

(a) Pharmaceutical billings must contain the National Drug Code (NDC) to identify the drug or biological billed. This includes compounded drugs, which must be billed by ingredient, listing each ingredient's NDC. Ingredients without an NDC are not reimbursable.

(b) All bills from pharmacies must include the prescribing provider's NPI or license number.

(c) Unless otherwise provided by contract, insurers must pay medical providers for prescription medication, including injectable drugs, at the medical provider's usual fee, or the maximum allowable fee, whichever is less. However, drugs provided by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

(d) Unless directly purchased by the worker (see 009-0025(5)), the maximum allowable fee for pharmaceuticals is calculated according to the following table:

If the drug dispensed is:	Then the maximum allowable fee is:
A generic drug	83.5 % of the dispensed drug's AWP plus a $2.00 dispensing fee
A brand name drug without a generic equivalent or the prescribing provider has specified that the drug may not be substituted with a generic equivalent	83.5 % of the dispensed drug's AWP plus a $2.00 dispensing fee
A brand name drug with a generic equivalent and the prescribing provider has not prohibited substitution	83.5 % of the average AWP for the class of generic drugs plus a $2.00 dispensing fee
A compound drug	83.5 % of the AWP for each individual ingredient plus a single compounding fee of $10.00 (The compounding fee includes the dispensing fee.)

(Note: "AWP" means the Average Wholesale Price effective on the date the drug was dispensed.)

(e) Insurers must use a nationally published prescription pricing guide for calculating payments to the provider, e.g., RED BOOK or Medi-Span.

(3) **Clinical Justification Form 4909.**

(a) The prescribing provider must fill out Form 4909, Pharmaceutical Clinical Justification for Workers' Compensation, and submit it to the insurer when prescribing more than a five day supply of the following drugs:

(A) Celebrex®,

(B) Cymbalta®,

(C) Fentora®,

(D) Kadian®,

(E) Lidoderm®,

(F) Lyrica®, or

(G) OxyContin®.

(b) Insurers may not challenge the adequacy of the clinical justification. However, they may challenge whether or not the medication is excessive, inappropriate, or ineffectual under ORS 656.327.

(c) The prescribing provider is not required to fill out Form 4909 for refills of medications listed on that form.

(d) If a prescribing provider does not submit Form 4909, Pharmaceutical Clinical

Justification for Workers' Compensation, to the insurer, the insurer may file a complaint with the director.

(4) **Dispensing by Medical Service Providers.**

(a) Except in an emergency, prescription drugs for oral consumption dispensed by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the patient, up to a maximum of 10 days.

(b) For dispensed over-the-counter medications, the insurer must pay the retail-based fee.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248, 656.252, 656.254
Hist: Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0110 Interpreters

(1) **Choosing an Interpreter.**

A patient may choose a person to communicate with a medical provider when the patient and the medical provider speak different languages, including sign language. The patient may choose a family member, a friend, an employee of the medical provider, or an interpreter. The medical provider may disapprove of the patient's choice at any time the medical provider feels the interpreter services are not improving communication with the patient, or feels the interpretation is not complete or accurate.

(2) **Billing.**

(a) Interpreters must charge the usual fee they charge to the general public for the same service.

(b) Interpreters may only bill an insurer or, if provided by contract, a managed care organization (MCO). However, if the insurer denies the claim, interpreters may bill the patient.

(c) Interpreters may bill for interpreter services and for mileage when the round-trip mileage is 15 or more miles. For the purpose of this rule, "mileage" means the number of miles traveling from the interpreter's starting point to the exam or treatment location and back to the interpreter's starting point.

(d) If the interpreter arrives at the provider's office for an appointment that was required by the insurer or the director, e.g., an independent medical exam, a physician review exam, or an arbiter exam, the interpreter may bill for interpreter services and mileage according to section (2)(c) of this rule even if:

(A) The patient fails to attend the appointment; or

(B) The provider has to cancel or reschedule the appointment.

(e) If interpreters do not know the workers' compensation insurer responsible for the claim, they may contact the Department of Consumer and Business Services', Workers' Compensation Division at 503-947-7814. They may also access insurance policy information at http://www4.cbs.state.or.us/ex/wcd/cov/index.cfm.

(3) **Billing and Payment Limitations.**

(a) When an appointment was not required by the insurer or director, interpreters may not bill any amount for interpreter services or mileage if:

(A) The patient fails to attend the appointment: or

(B) The provider cancels or reschedules the appointment.

(b) The insurer is not required to pay for interpreter services or mileage when the services are provided by:

(A) A family member or friend of the patient; or

(B) A medical provider's employee.

(4) **Billing Timelines.**

(a) Interpreters must bill within:

(A) 60 days of the date of service;

(B) 60 days after the interpreter has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or

(C) 60 days after any litigation affecting the compensability of the service is final, if the interpreter receives written notice of the final litigation from the insurer.

(b) If the interpreter bills past the timelines outlined in subsection (a) of this section, the interpreter may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.

(c) When submitting a bill later than outlined in subsection (a) of this section, an interpreter must establish good cause. Good cause may include, but is not limited to, extenuating circumstances or circumstances considered outside the control of the interpreter.

(d) A bill is considered sent by the date the envelope is post-marked or the date the document is faxed.

(5) **Billing Form.**

(a) Interpreters must use an invoice when billing for interpreter services and mileage and use Oregon specific code:

(A) D0004 for interpreter services except American Sign Language,

(B) D0005 for American Sign Language interpreter services, and

(C) D0041 for mileage.

(b) An interpreter's invoice must include:

(A) The interpreter's name, the interpreter's company name, if applicable, billing address, and phone number;

(B) The patient's name;

(C) The patient's workers' compensation claim number, if known;

(D) The correct Oregon specific codes for the billed services (D0004, D0005, or D0041);

(E) The workers' compensation insurer's name and address;

(F) The date interpreter services were provided;

(G) The name and address of the medical provider that conducted the exam or provided treatment;

(H) The total amount of time interpreter services were provided; and

(I) The mileage, if the round trip was 15 or more miles.

(6) Payment Calculations.

(a) Unless otherwise provided by contract, insurers must pay the lesser of the maximum allowable payment amount or the interpreter's usual fee.

(b) Insurers must use the following table to calculate the maximum allowable payment for interpreters:

For:	The maximum payment is:
Interpreter services of an hour or less	$60.00
American sign language (ASL) interpreter services of an hour or less	$70.00
Interpreter services of more than one hour	$15.00 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
American sign language (ASL) interpreter services of more than one hour	$17.50 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
Mileage of less than 15 miles round trip	No payment allowed
Mileage of 15 or more miles round trip	The private vehicle mileage rate published in Bulletin 112
An examination required by the director or insurer that the patient fails to attend or when the provider cancels or reschedules	$60.00 no-show fee plus payment for mileage if 15 or more miles round trip
An interpreter who is the only person in Oregon able to interpret a specific language	The amount billed for interpreter services and mileage

(7) Payment Requirements.

(a) When the medical exam or treatment is for an accepted claim or condition, the insurer must pay for interpreter services and mileage if the round-trip mileage is 15 or more miles.

(b) When the patient fails to attend or the provider cancels or reschedules a medical exam required by the director or the insurer, the insurer must pay the no-show fee and mileage if the round-trip mileage is 15 or more miles.

(c) The insurer must pay the interpreter within:

(A) 14 days of the date of claim acceptance or any action causing the service to be payable, or 45 days of receiving the invoice, whichever is later; or

(B) 45 days of receiving the invoice for an exam required by the insurer or director.

(d) When an interpreter bills within 12 months of the date of service, the insurer may not reduce payment due to late billing.

(e) When an interpreter bills over 12 months after the date of service, the bill is not payable, except when a provision of subsection (4)(c) of this rule is the reason the billing was submitted after 12 months.

(f) If the insurer does not receive all the information to process the invoice, the insurer must return the invoice to the interpreter within 20 days of receipt. The insurer must provide specific information about what is needed to process the invoice.

(g) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each service billed.

(h) The insurer must provide a written explanation of benefits for services paid or denied and must send the explanation to the interpreter that billed for the services. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. All the information on the written explanation must be in 10 point size font or larger.

(i) Electronic and written explanations must include:

(A) The payment amount for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;

(B) The specific reason for non-payment, reduced payment, or discounted payment for each service billed;

(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to an interpreter's payment questions within two days, excluding weekends and legal holidays;

(D) The following notice, Web link, and phone number:

"To access the information about Oregon's Medical Fee and Payment rules, visit www.oregonwcdoc.info or call 503-947-7606";

(E) Space for a signature and date; and

(F) A notice of the right to administrative review as follows:

"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."

(j) The insurer or its representative must respond to an interpreter's inquiry about payment within two days, not including weekends or legal holidays. The insurer or its

representative may not refer the interpreter to another entity to obtain the answer.

(k) The insurer or its representative and an interpreter may agree to send and receive payment information by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 to 646A.628 and federal law.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.245, 656.248
Hist: Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0998 Sanctions and Civil Penalties

(1) The director may impose sanctions upon a medical provider or insurer for violation of these rules in accordance with OAR 436-010-0340.

(2) If an insurer applies a contract or fee discount agreement to a provider's bill that is incorrect, the insurer must pay the provider's bill at the provider's usual fee or according to the fee schedule, whichever is less, and the insurer may be subject to a civil penalty.

(3) Although insurers may contract with provider networks for certain services, the insurer is responsible for their own actions as well as the actions of others acting on the insurer's behalf. If an insurer or someone acting on the insurer's behalf violates any provision of these rules, the director may impose a civil penalty against the insurer.

(4) If the director finds a pattern and practice, or an egregious violation of applying incorrect discounts to providers' fees under these rules, by an insurer or someone acting on the insurer's behalf, the director may issue a civil penalty up to the amount allowed under ORS chapter 656

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.254, 656.745
Hist: Amended 3/12/15 as Admin Order 15-058, eff. 4/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

Appendix A - Matrix for health care provider types* See OAR 436-009-0005

	Attending physician status (primarily responsible for treatment of a patient)	Provide compensable medical services for initial injury or illness	Authorize payment of time loss (temporary disability) and release the patient to work	Establish impairment findings (permanent disability)	Provide compensable medical services for aggravation of injury or illness
Type A attending physician Medical doctor Doctor of osteopathy Oral and maxillofacial surgeon Podiatric physician and surgeon	Yes	Yes	Yes	Yes	Yes
Type B attending physician Chiropractic physician Naturopathic physician Physician assistant	Yes, for a total of 60 consecutive days or 18 visits, from the date of the initial visit on the initial claim with any Type B attending physician.	Yes, unless the total of 60 consecutive days or 18 visits from the date of the initial visit on the initial claim with any Type B attending physician has passed. Or, if authorized by an attending physician and under a treatment plan. (Note: physician assistants are not required to have a written treatment plan)	Yes, 30 days from the date of the first visit with any type B attending physician on the initial claim, if within the specified 18 visit period.	No, unless the type B attending physician is a chiropractic physician.	No, unless authorized by attending physician and under a written treatment plan (Note: physician assistants are not required to have a written treatment plan)
Emergency room physicians	No, if the physician refers the patient to a primary care physician	Yes	ER physicians may authorize time loss for up to 14 days only, including retroactive authorization	No, if patient referred to a primary care physician	Yes
Authorized nurse practitioner	No	Yes, for 180 consecutive days from the date of the first visit to any authorized nurse practitioner on the initial claim. Or if authorized by attending physician.	Yes, for 180 days from the date of the first visit on the initial claim.	No	No, unless authorized by the attending physician
"Other Health Care Providers" e.g. acupuncturists	No	Yes, for 30 consecutive days or 12 visits from the date of the first visit on the initial claim with any "Other Health Care" providers. Thereafter, services must be provided under a treatment plan and authorized by the attending physician.	No	No	No, unless referred by the attending physician and under a written treatment plan

* This matrix does not apply to Managed Care Organizations

Appendix B through E

Oregon Workers' Compensation Maximum Allowable Payment Amounts

The Workers' Compensation Division no longer adopts the Federal Register that publishes Centers for Medicare and Medicaid Services' (CMS) relative value units (RVUs). The division publishes the following Appendices to the division 009 of chapter 436.

Appendix B (physician fee schedule) containing the maximum allowable payment amounts for services provided by medical service providers.
[Effective April 1, 2016]

Appendix C (ambulatory surgery center fee schedule amounts for surgical procedures), containing the maximum allowable payment amounts for surgical procedures including packaged procedures.
[Effective April 1, 2016]

Appendix D (ambulatory surgery center fee schedule amounts for ancillary services) containing the maximum allowable payment amounts for ancillary services integral to the surgical procedure.
[Effective April 1, 2016]

Appendix E (durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)) containing the maximum allowable payment amounts for durable medical equipment, prosthetics, orthotics, and supplies. [Effective April 1, 2016]

Note: If the above links do not connect you to the division's website, click: http://wcd.oregon.gov/medical/Pages/disclaimer.aspx.

If you have questions, call the Workers' Compensation Division, 503-947-7606.

The five character codes included in the Oregon Workers' Compensation Maximum Allowable Payment Tables are obtained from Current Procedural Terminology (CPT), copyright 2015 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

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Link to the Maximum Allowable Payment Tables: http://wcd.oregon.gov/medical/Pages/disclaimer.aspx.

Or, contact the division for a paper copy, 503-947-7717

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 010

MEDICAL SERVICES

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436-010-0001 Administration of These Rules

(1) Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.

(2) **Authority for Rules.**

These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) for administration of and pursuant to ORS chapter 656, particularly: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794.

(3) **Purpose.** [Formerly rule 0002]

The purpose of these rules is to establish uniform guidelines for administering the delivery of and payment for medical services to workers within the workers' compensation system.

(4) **Applicability of Rules.** [Formerly rule 0003]

(a) These rules apply on or after the effective date to carry out the provisions of ORS 656.245, 656.247, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794, and govern all providers of medical services licensed or authorized to provide a product or service under ORS chapter 656.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, 656.794
Hist: Amended 3/7/16 as Admin. Order 16-051, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0005 Definitions

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made part of these rules.

(2) "Administrative review" means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001.

(3) "Attending physician" has the same meaning as described in ORS 656.005(12)(b). See Appendix A "Matrix for Health Care Provider Types."

(4) "Authorized nurse practitioner" means a nurse practitioner licensed under ORS 678.375 to 678.390 who has certified to the director that the nurse practitioner has reviewed informational materials about the workers' compensation system provided by the director and who has been assigned an authorized nurse practitioner number by the director.

(5) "Board" means the Workers' Compensation Board and includes its Hearings Division.

(6) "Chart note" means a notation made in chronological order in a medical record in which the medical service provider records information such as subjective and objective findings, diagnosis, treatment rendered, treatment objectives, and return-to-work goals and status.

(7) "Come-along provider" means a primary care physician, chiropractic physician, or an authorized nurse practitioner who is not a managed care organization (MCO) panel provider and who continues to treat the worker when the worker becomes enrolled in an MCO. (See OAR 436-015-0070.)

(8) "Date stamp" means to stamp or display the initial receipt date and the recipient's name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.

(9) "Days" means calendar days.

(10) "Direct control and supervision" means the physician is on the same premises, at the same time, as the person providing a medical service ordered by the physician. The physician can modify, terminate, extend, or take over the medical service at any time.

(11) "Direct medical sequela" means a condition that is clearly established medically and originates or stems from an accepted condition. For example: The accepted condition is low back strain with herniated disc at L4-5. The worker develops permanent weakness in the leg and foot due to the accepted condition. The weakness is considered a "direct medical sequela."

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

(13) "Eligible worker" means a worker who has filed a claim or who has an accepted claim and whose employer is located in an MCO's authorized geographical service area, covered by an insurer that has a contract with that MCO.

(14) "Enrolled" means an eligible worker has received notification from the insurer that the worker is being required to treat under the provisions of a managed care organization (MCO). However, a worker may not be enrolled who would otherwise be subject to an MCO contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical service area.

(15) "Health care practitioner or health care provider" has the same meaning as a "medical service provider."

(16) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(17) "Home health care" means necessary medical and medically related services provided in the patient's home environment. These services may include, but are not limited to, nursing care, medication administration, personal hygiene, or assistance with mobility and transportation.

(18) "Hospital" means an institution licensed by the State of Oregon as a hospital.

(19) "Initial claim" means the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared to be medically stationary by an attending physician or authorized nurse practitioner. For nondisabling claims, the "initial claim" means the first period of medical treatment immediately following the original filing of the occupational injury or disease claim ending when the attending physician or authorized nurse practitioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

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

(21) "Interim medical benefits" means those services provided under ORS 656.247 on initial claims with dates of injury on or after January 1, 2002 that are not denied within 14 days of the employer's notice of the claim.

(22) "Mailed or mailing date" means the date a document is postmarked. Requests submitted by facsimile or "fax" are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped by the Workers' Compensation Division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

(23) "Managed care organization" or "MCO" means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

(24) "Medical evidence" includes, but is not limited to: expert written testimony; written statements; written opinions, sworn affidavits, and testimony of medical professionals; records, reports, documents, laboratory, X-ray and test results authored, produced, generated, or verified by medical professionals; and medical research and reference material used, produced, or verified by medical professionals who are physicians or medical record reviewers in the particular case under consideration.

(25) "Medical provider" means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.

(26) "Medical service" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, or other related services; drugs, medicine, crutches, prosthetic appliances, braces, and supports; and where necessary, physical restorative services.

(27) "Medical service provider" means a person duly licensed to practice one or more of the healing arts.

(28) "Medical treatment" means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker's condition through conservative care.

(29) "Parties" mean the worker, insurer, MCO, attending physician, and other medical provider, unless a specific limitation or exception is expressly provided for in the statute.

(30) "Patient" means the same as worker as defined in ORS 656.005(30).

(31) "Physical capacity evaluation" means an objective, directly observed, measurement of a worker's ability to perform a variety of physical tasks combined with subjective analyses of abilities by worker and evaluator. Physical tolerance screening, Blankenship's Functional Capacity Evaluation, and Functional Capacity Assessment have the same meaning as Physical Capacity Evaluation.

(32) "Physical restorative services" means those services prescribed by the attending physician or authorized nurse practitioner to address permanent loss of physical function due to hemiplegia or a spinal cord injury, or to address residuals of

a severe head injury. Services are designed to restore and maintain the patient's highest functional ability consistent with the patient's condition.

(33) "Report" means medical information transmitted in written form containing relevant subjective or objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the director.

(34) "Residual functional capacity" means a patient's remaining ability to perform work-related activities. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the patient can perform each activity.

(35) "Specialist physician" means a licensed physician who qualifies as an attending physician and who examines a patient at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice or an opinion regarding the treatment being rendered, or considered, for a patient's compensable injury.

(36) "Work capacity evaluation" means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work Tolerance Screening has the same meaning as Work Capacity Evaluation.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.000 et seq.; 656.005
Hist: Amended 3/7/16 as Admin. Order 16-051, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0008 Request for Review before the Director

(1) General.

(a) Administrative review before the director:

(A) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all disputes concerning medical fees, non-payment of compensable medical bills, and medical service and treatment disputes arising under ORS 656.245, 656.247, 656.248, 656.260, 656.325, and 656.327. Disputes about whether a medical service provided after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c), or whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review before the director.

(B) A party does not need to be represented to participate in the administrative review before the director.

(C) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed.

(b) All issues pertaining to disagreements about medical services within a managed care organization (MCO), including disputes under ORS 656.245(4)(a) about whether a change of provider will be medically detrimental to the worker, are subject to ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting an administrative review of the matter before the director.

(c) Except for disputes regarding interim medical benefits under ORS 656.247, when there is a formal denial of the compensability of the underlying claim, or a denial of the causal relationship between the medical service or treatment and the accepted condition or the underlying condition, the parties may file a request for hearing with the Hearings Division of the Workers' Compensation Board to resolve the compensability issue.

(d) The director may, on the director's own motion, initiate a review of medical services or medical treatment at any time.

(e) If the director issues an order declaring an already rendered medical treatment or medical service inappropriate, or otherwise in violation of the statute or medical rules, the worker is not obligated to pay for such.

(2) Time Frames and Conditions.

(a) The following time frames and conditions apply to requests for administrative review before the director under this rule:

(A) For MCO-enrolled claims, a party that disagrees with an action or decision of the MCO must first use the MCO's dispute resolution process. If the party does not appeal the MCO's decision using the MCO's dispute resolution process, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision unless the party can show good cause. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision.

(B) For MCO-enrolled claims, if a party disagrees with the final action or decision of the MCO, the aggrieved party must request administrative review before the director within 60 days of the MCO's final decision. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 60-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. If a party has been denied access to the MCO dispute resolution process, or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process. If the MCO does not have a process for resolving a particular type of dispute, the insurer or the MCO must advise the medical provider or worker that they may request review before the director.

(C) For claims not enrolled in an MCO, or for disputes that do not involve an action or decision of an MCO, the aggrieved party must request administrative review before the director within 90 days of the date the party knew, or should have

known, there was a dispute. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 90-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due. For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, whichever occurs last. A request for administrative review under this rule may also be filed as prescribed in OAR chapter 438, division 005.

(b) Medical provider bills for treatment or services that are under review before the director are not payable during the review.

(3) Form and Required Information.

(a) Requests for administrative review before the director should be made on Form 2842 as described in Bulletin 293. When an insurer or a worker's representative submits a request without the required information, the director may dismiss the request or hold initiation of the administrative review until the required information is submitted. Unrepresented workers may ask the director for help in meeting the filing requirements. The requesting party must simultaneously notify all other interested parties and their representatives, if known, of the dispute. The notice must:

(A) Identify the worker's name, date of injury, insurer, and claim number;

(B) Specify the issues in dispute and the relief sought; and

(C) Provide the specific dates of the unpaid disputed treatment or services.

(b) In addition to medical evidence relating to the dispute, all parties may submit other relevant information, including written factual information, sworn affidavits, or legal argument, for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain additional evidence consistent with statute, such as pertinent medical treatment and payment records. The director may also interview parties to the dispute, or consult with an appropriate committee of the medical provider's peers. When a party receives a written request for additional information from the director, the party must respond within 14 days.

(c) When a request for administrative review is filed under ORS 656.247, 656.260, or 656.327, the insurer must provide a record packet, at no charge, to the director and all other parties or their representatives as follows:

(A) The packet must include a complete, indexed copy of the worker's medical record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number must be preceded by the designation "Ex." and pagination of the multiple page documents must be designated by a hyphen followed by the page number. For example, page two of document 10 must be designated "Ex. 10-2." The index must include the document numbers, description of each document, author, number of pages, and date of the document. The packet must include the following notice in bold type:

We hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order that could affect reimbursement for the disputed medical service(s).

(B) If the insurer requests review, the packet must accompany the request, with copies sent simultaneously to the other parties.

(C) If the requesting party is not the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer must provide the record within 14 days of the director's request as described in this rule.

(D) If the insurer fails to submit the record in the time and format specified in this rule, the director may sanction the insurer under OAR 436-010-0340.

(E) Except for disputes regarding interim medical benefits, the packet must include certification stating that there is an issue of compensability of the underlying claim or condition or stating that there is not an issue of compensability of the underlying claim or condition. If the insurer issued a denial that has been reversed by the Hearings Division, the Board, or the Court of Appeals, the insurer must provide a statement regarding its intention, if known, to accept or appeal the decision.

(4) Physician Review (E.g., appropriateness).

If the director determines a review by a physician is indicated to resolve the dispute, the director, under OAR 436-010-0330, may appoint an appropriate medical service provider or panel of providers to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. Notwithstanding ORS 656.325(1), if the worker is required by the director to submit to a medical exam as part of the administrative review process, the worker may refuse an invasive test without sanction.

(a) A single physician selected to conduct a review must be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment or service is being reviewed.

(b) When a panel of physicians is selected, at least one panel member must be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment or service is being reviewed.

(c) When such an exam of the worker is required, the director will notify the appropriate parties of the date, time, and location of the exam. Examinations will be at a place reasonably convenient to the worker, if possible. The parties must not directly contact the physician or panel unless it relates to the exam date, time, location, or attendance. If the

parties have special questions they want addressed by the physician or panel, the questions must be submitted to the director for screening as to the appropriateness of the questions. Matters not related to the issues before the director are inappropriate for medical review and will not be submitted to the reviewing physician(s). The exam may include, but is not limited to:

(A) A review of all medical records and diagnostic tests submitted,

(B) An examination of the worker, and

(C) Any necessary and reasonable medical tests.

(5) Dispute Resolution by Agreement (E.g., Alternative Dispute Resolution).

(a) A dispute may be resolved by agreement between the parties to the dispute. The agreement must be in writing and approved by the director. The director may issue a letter of agreement instead of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) A party fails to honor the agreement;

(B) The agreement was based on misrepresentation;

(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or

(D) All parties request revision or reinstatement of the dispute.

(b) Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney.

(c) If the dispute does not resolve through mediation or alternative dispute resolution, the director will issue an order. If the dispute is not resolved by agreement and if the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order under ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical dispute exists, the party may appeal the order to the Workers' Compensation Board within 30 days of the mailing date of the order. Upon review, the order of the director may be modified only if it is not supported by substantial evidence in the record developed by the director.

(6) Director Order and Reconsideration.

(a) The director may, on the director's own motion, reconsider or withdraw any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new information that could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request must be received by the director before the administrative order becomes final.

(b) During any reconsideration of the administrative order, the parties may submit new material evidence consistent with this rule and may respond to such evidence submitted by others.

(c) Any party requesting reconsideration or responding to a reconsideration request must simultaneously notify all other interested parties of its contentions and provide them with copies of all additional information presented.

(d) Attorney fees in administrative review will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 through 436-001-0440.

(7) Hearings.

(a) Any party that disagrees with an action or administrative order under these rules may obtain review of the action or order by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the action or order under ORS 656.245, 656.248, 656.260, or 656.327, or within 60 days of the mailing date of an action or order under ORS 656.247. OAR 436-001 applies to the hearing.

(b) In the review of orders issued under ORS 656.245, 656.247, 656.260(15) or (16), or 656.327(2), no new medical evidence or issues will be admitted at hearing. In these reviews, an administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(c) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as follows:

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

(B) The request must be mailed to the administrator within 60 days after the mailing date of the order or notice of assessment.

(C) The administrator will forward the request and other pertinent information to the Workers' Compensation Board.

(8) Other Proceedings.

(a) Any party seeking an action or decision by the director, or any party aggrieved by an action taken by another party not covered under sections (1) through (7) of this rule, may request administrative review before the director.

(b) A written request for review must be sent to the administrator of the Workers' Compensation Division within 90 days of the disputed action and must specify the grounds upon which the action is contested.

(c) The administrator may require and allow such input and information as it deems appropriate to complete the review.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704
Hist: Amended 3/7/16 as Admin. Order 16-051, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0200 Medical Advisory Committee

The Medical Advisory Committee members are appointed by the director of the Department of Consumer and Business Services. The committee must include one insurer representative, one employer representative, one worker representative, one managed care organization representative, and a diverse group of health care providers representative of those providing medical care to injured or ill workers.

The director may appoint other persons as may be determined necessary to carry out the purpose of the committee. Health care providers must comprise a majority of the committee at all times. When appointing members, the director should select health care providers who will consider the perspective of specialty care, primary care, and ancillary care providers and consider the ability of members to represent the interests of the community at large.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.794
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0210 Attending Physician, Authorized Nurse Practitioner, and Time-Loss Authorization

(1) An attending physician or authorized nurse practitioner is primarily responsible for the patient's care, authorizes time loss, and prescribes and monitors ancillary care and specialized care.

(a) No later than five days after becoming a patient's attending physician or authorized nurse practitioner, the provider must notify the insurer using Form 827. Regardless of whether Form 827 is filed, the facts of the case and the actions of the provider determine if the provider is the attending physician or authorized nurse practitioner.

(b) Type A and B attending physicians and authorized nurse practitioners may authorize time loss and manage medical services subject to the limitations of ORS chapter 656 or a managed care organization contract. (See Appendix A "Matrix for Health Care Provider Types")

(c) Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be approved by the worker's attending physician or authorized nurse practitioner.

(2) Emergency Room Physicians.

Emergency room physicians may authorize time loss for no more than 14 days when they refer the patient to a primary care physician. If an emergency room physician sees a patient in his or her private practice apart from their duties as an emergency room physician, the physician may be the attending physician.

(3) Authorized Nurse Practitioners.

(a) In order to provide any compensable medical service, a nurse practitioner licensed in Oregon under ORS 678.375 to 678.390 must review a packet of materials provided by the division and complete the statement of authorization. (See www.oregonwcdoc.info) Once the nurse practitioner has completed the statement of authorization, the division will assign an authorized nurse practitioner number.

(b) An authorized nurse practitioner may:

(A) Provide compensable medical services to an injured worker for a period of 180 days from the date of the first visit with a nurse practitioner on the initial claim. Thereafter, medical services provided by an authorized nurse practitioner are not compensable without the attending physician's authorization; and

(B) Authorize temporary disability benefits for a period of up to 180 days from the date of the first nurse practitioner visit on the initial claim.

(4) Unlicensed to Provide Medical Services.

Attending physicians may prescribe services to be carried out by persons not licensed to provide a medical service or treat independently. These services must be rendered under the physician's direct control and supervision. Home health care provided by a patient's family member is not required to be provided under the direct control and supervision of the attending physician if the family member demonstrates competency to the satisfaction of the attending physician.

(5) Out-of-State Attending Physicians.

The worker may choose an attending physician outside the state of Oregon with the approval of the insurer. When the insurer receives the worker's request or becomes aware of the worker's request to treat with an out-of-state attending physician, the insurer must give the worker written notice of approval or disapproval of the worker's choice of attending physician within 14 days.

(a) If the insurer approves the worker's choice of out-of-state attending physician, the insurer must immediately notify the worker and the physician in writing of the following:

(A) The Oregon medical fee and payment rules, OAR 436-009;

(B) The manner in which the out-of-state physician may provide compensable medical treatment or services to Oregon workers; and

(C) That the insurer cannot pay bills for compensable services above the Oregon fee schedule.

(b) If the insurer disapproves the worker's out-of-state attending physician, the notice to the worker must:

(A) Clearly state the reasons for the disapproval, for example, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010,

(B) Identify at least two other physicians of the same healing art and specialty in the same area that the insurer would approve, and

(C) Inform the worker that if the worker disagrees with the disapproval, the worker may request approval from the director under OAR 436-010-0220.

(6) If an approved out-of-state attending physician does not comply with OAR 436-009 or 436-010, the insurer may withdraw approval of the attending physician. The insurer must notify the worker and the physician in writing:

(a) The reasons for withdrawing the approval,

(b) That any future services provided by that physician will not be paid by the insurer, and

(c) That the worker may be liable for payment of services provided after the date of notification.

(7) If the worker disagrees with the insurer's decision to disapprove an out-of-state attending physician, the worker or worker's representative may request approval from the director under OAR 436-010-0220.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.005(12), 656.245, 656.260
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0220 Choosing and Changing Medical Providers

(1) The worker may have only one attending physician or authorized nurse practitioner at a time. Concurrent treatment or services by other medical providers, including specialist physicians, must be sufficiently different that separate medical skills are needed for proper care, and must be based on a written referral by the attending physician or authorized nurse practitioner. The referral must specify any limitations and a copy must be sent to the insurer. A specialist physician is authorized to provide or order all compensable medical services and treatment he or she considers appropriate, unless the referral is for a consultation only. The attending physician or authorized nurse practitioner continues to be responsible for authorizing temporary disability even if the specialist physician is providing or authorizing medical services and treatment. Physicians who provide the following services are not considered attending physicians:

(a) Emergency services;

(b) Insurer or director requested examinations;

(c) A Worker Requested Medical Examination;

(d) Consultations or referrals for specialized treatment or services initiated by the attending physician or authorized nurse practitioner; and

(e) Diagnostic studies provided by radiologists and pathologists upon referral.

(2) Changing Attending Physician or Authorized Nurse Practitioner.

The worker may choose to change his or her attending physician or authorized nurse practitioner only twice after the initial choice. When the worker requests a referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, the change will count as one of the worker's choices. The limitation of the worker's right to choose attending physicians or authorized nurse practitioners begins with the date of injury and extends through the life of the claim. The following are not considered changes of attending physician or authorized nurse practitioner initiated by the worker and do not count toward the worker's two changes:

(a) When the worker has an attending physician or authorized nurse practitioner who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines;

(b) When the worker's attending physician or authorized nurse practitioner is not available and the worker sees a medical provider who is covering for that provider in their absence; or

(c) When the worker is required to change attending physician or authorized nurse practitioner due to conditions beyond the worker's control. This could include, but is not limited to:

(A) When the attending physician or authorized nurse practitioner terminates practice or leaves the area;

(B) When the attending physician or authorized nurse practitioner is no longer willing to treat the worker;

(C) When the worker moves out of the area requiring more than a 50 mile commute to the attending physician or authorized nurse practitioner;

(D) When the period for treatment or services by a type B attending physician or an authorized nurse practitioner has expired (See Appendix A "Matrix for Health Care Provider Types");

(E) When the authorized nurse practitioner is required to refer the worker to an attending physician for a closing examination or because of a possible worsening of the worker's condition following claim closure;

(F) When the worker becomes subject to a managed care organization (MCO) contract and must change to an attending physician or authorized nurse practitioner on the MCO's panel;

(G) When the worker who, at the time of MCO enrollment was required to change attending physician or authorized nurse practitioner, is disenrolled from an MCO; or

(H) When the worker has to change because their attending physician or authorized nurse practitioner is no longer qualified as an attending physician or authorized to continue providing compensable medical services.

(3) Insurer Notice to the Worker.

When the worker has changed attending physicians or authorized nurse practitioners twice by choice or has reached the maximum number of changes established by the MCO, the insurer must notify the worker by certified mail that any additional changes by choice must be approved by the insurer or the director. If the insurer fails to provide such notice and the worker later chooses another attending physician or authorized nurse practitioner, the insurer must pay for compensable medical services rendered prior to notice to the worker. The insurer must notify the newly selected provider that the worker was not allowed to change his or her attending physician or authorized nurse practitioner without approval of the insurer or director, and therefore any future services will not be paid. The insurer must pay for appropriate medical services rendered prior to this notification.

(4) Worker Requesting Additional Changes of Attending Physician or Authorized Nurse Practitioner.

(a) If a worker not enrolled in an MCO has changed attending physicians or authorized nurse practitioners by choice twice (or for MCO enrolled workers, the maximum allowed by the MCO) and wants to change again, the worker must request approval from the insurer. The worker must make the request in writing or by signing Form 827. The insurer must respond to the worker within 14 days of receiving the request whether the change is approved. If the insurer objects to the change, the insurer must:

(A) Send the worker a written explanation of the reasons;

(B) Send the worker Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner); and

(C) Inform the worker that he or she may request director approval by sending Form 2332 to the director.

(b) When the worker submits a request to the director for an additional change of attending physician or authorized nurse practitioner, the director may request, in writing, additional information. If the director requests additional information, the parties must respond in writing within 14 days of the director's request.

(c) The director will issue an order advising whether the request for change of attending physician or authorized nurse practitioner is approved. On a case-by-case basis the director will consider circumstances, such as:

(A) Whether there is medical justification for a change, e.g., whether the attending physician or authorized nurse practitioner can provide the type of treatment or service that is appropriate for the worker's condition.

(B) Whether the worker has moved to a new area and wants to establish an attending physician or authorized nurse practitioner closer to the worker's residence.

(d) Any party that disagrees with the director's order may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order.

(5) Managed Care Organization (MCO) Enrolled Workers.

An MCO enrolled worker must choose:

(a) A panel provider unless the MCO approves a non-panel provider, or

(b) A "come-along provider" who provides medical services subject to the terms and conditions of the governing MCO.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.252, 656.260
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0225 Choosing a Person to Provide Interpreter Services

A worker may choose a person to communicate with a medical provider when the worker and the medical provider speak different languages, including sign language. The worker may choose a family member, a friend, an employee of the medical provider, or someone who provides interpreter services as a profession. The medical provider may disapprove of the worker's choice at any time the medical provider feels the interpreter services are not improving communication with the worker, or feels the interpretation is not complete or accurate.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245
Adopted 5/27/10, as Admin. Order 10-053, eff. 7/1/10

436-010-0230 Medical Services and Treatment Guidelines

(1) Medical services provided to the worker must not be more than the nature of the compensable injury or the process of recovery requires. Services that are unnecessary or inappropriate according to accepted professional standards are not reimbursable.

(2) If the provider's chart notes do not provide evidence of frequency, extent, and efficacy of treatment and services, the insurer may request additional information from the provider.

(3) All medical service providers must notify the patient at the time of the first visit of how they can provide compensable medical services and authorize time loss. Providers must also notify patients that they may be personally liable for noncompensable medical services. Such notification should be made in writing or documented in the patient's medical record.

(4) Consent to Attend a Medical Appointment.

(a) An employer or insurer representative, such as a nurse case manager, may not attend a patient's medical appointment without written consent of the patient. The patient has the right to refuse such attendance.

(A) The consent form must be written in a way that allows the patient to understand it and to overcome language or cultural differences.

(B) The consent form must state that the patient's benefits cannot be suspended if the patient refuses to have an employer or insurer representative present.

(C) The insurer must keep a copy of the signed consent form in the claim file.

(b) The patient or the medical provider may refuse to allow an employer or insurer representative to attend an appointment at any time, even if the patient previously signed a consent form. The medical provider may refuse to meet with the employer or insurer representative.

(5) Request for Records at a Medical Appointment.

The medical provider may refuse to provide copies of the patient's medical records to the insurer representative without proof that the person is representing the insurer. The provider may charge for any copies that are provided.

(6) Requesting a Medical Provider Consultation.

The attending physician, authorized nurse practitioner, or the MCO may request a consultation with a medical provider regarding conditions related to an accepted claim. MCO-requested consultations that are initiated by the insurer, which include an exam of the worker, must be considered independent medical exams under OAR 436-010-0265.

(7) Ancillary Services – Treatment Plan.

(a) Ancillary medical service providers include but are not limited to physical or occupational therapists, chiropractic or naturopathic physicians, and acupuncturists. When an attending or specialist physician or an authorized nurse practitioner prescribes ancillary services, unless an MCO contract specifies other requirements, the ancillary provider must prepare a treatment plan before beginning treatment.

(b) The ancillary medical service provider must send the treatment plan to the prescribing provider and the insurer within seven days of beginning treatment. If the treatment plan is not sent within seven days, the insurer is not required to pay for the services provided before the treatment plan is sent.

(c) The treatment plan must include objectives, modalities, frequency of treatment, and duration. The treatment plan may be in any legible format, e.g., chart notes.

(d) Treatment plans required under this subsection do not apply to services provided under ORS 656.245(2)(b)(A). (See Appendix A "Other Health Care Providers.")

(e) Within 30 days of the beginning of ancillary services, the prescribing provider must sign a copy of the treatment plan and send it to the insurer. If the prescribing provider does not sign and send the treatment plan, the provider may be subject to sanctions under OAR 436-010-0340. However, this will not affect payment to the ancillary provider.

(f) Authorized nurse practitioners, out-of-state nurse practitioners, and physician assistants directed by the attending physician do not have to provide a written treatment plan as prescribed in this section.

(8) Massage Therapy.

Unless otherwise provided by an MCO, when an attending physician, authorized nurse practitioner, or specialist physician prescribes ancillary services provided by a massage therapist licensed by the Oregon State Board of Massage Therapists under ORS 687.011 to 687.250, the massage therapist must prepare a treatment plan before beginning treatment. Massage therapists not licensed in Oregon must provide their services under the direct control and supervision of the attending physician. Treatment plans provided by massage therapists must follow the same requirements as those for ancillary providers in section (7) of this rule.

(9) Therapy Guidelines and Requirements.

(a) Unless otherwise provided by an MCO's utilization and treatment standards, the usual range for therapy visits is up to 20 visits in the first 60 days, and four visits a month thereafter. This is only a guideline and insurers should not arbitrarily limit payment based on this guideline nor should the therapist arbitrarily use this guideline to exceed medically necessary treatment. The medical record must provide clinical justification when therapy services exceed these guidelines. When an insurer believes the treatment is inappropriate or excessive, the insurer may request director review as outlined in OAR 436-010-0008.

(b) Unless otherwise provided by an MCO, a physical therapist must submit a progress report to the attending physician (or authorized nurse practitioner) and the insurer every 30 days or, if the patient is seen less frequently, after every visit. The progress report may be part of the physical therapist's chart notes and must include:

(A) Subjective status of the patient;

(B) Objective data from tests and measurements conducted;

(C) Functional status of the patient;

(D) Interpretation of above data; and

(E) Any change in the treatment plan.

(10) Physical Capacity Evaluation.

The attending physician or authorized nurse practitioner must complete a physical capacity or work capacity evaluation within 20 days after the insurer or director requests the evaluation. If the attending physician or authorized nurse practitioner does not wish to perform the evaluation, they must refer the patient to a different provider within seven days of the request. The attending physician or authorized nurse practitioner must notify the insurer and the patient in writing if the patient is incapable of participating in the evaluation.

(11) Prescription Medication.

(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the worker is medically stationary. For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available) according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must pay the total cost of the brand-name drug out-of-pocket and request reimbursement from the insurer. However, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug. Except in an emergency, prescription drugs for oral consumption dispensed by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker, up to a maximum of 10 days. Unless otherwise provided by an MCO contract, the worker may choose the dispensing provider.

(b) Providers should review and are encouraged to adhere to the workers' compensation division's opioid guidelines. See http://wcd.oregon.gov/medical/Pages/opioid-guidelines.aspx.

(12) Diagnostics.

Unless otherwise provided by an MCO, a medical provider may contact an insurer in writing for pre-authorization of diagnostic imaging studies other than plain film X-rays. Pre-authorization is not a guarantee of payment. The insurer must respond to the provider's request in writing whether the service is pre-authorized or not pre-authorized within 14 days of receipt of the request.

(13) Articles.

Articles, including but not limited to, beds, hot tubs, chairs, and gravity traction devices are not compensable unless a report by the attending physician or authorized nurse practitioner clearly justifies the need. The report must:

(a) Establish that the nature of the injury or the process of recovery requires the item be furnished, and

(b) Specifically explain why the worker requires the item when the great majority of workers with similar impairments do not.

(14) Physical Restorative Services.

(a) Physical restorative services include, but are not limited to, a regular exercise program, personal exercise training, or swim therapy. They are not services to replace medical services usually prescribed during the course of recovery. Physical restorative services are not compensable unless:

(A) The nature of the worker's limitations requires specialized services to allow the worker a reasonable level of social or functional activity, and

(B) A report by the attending physician or authorized nurse practitioner clearly justifies why the worker requires services not usually considered necessary for the majority of workers.

(b) Trips to spas, resorts, or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

(15) Lumbar Artificial Disc Replacement Guidelines.

(a) Lumbar artificial disc replacement is always inappropriate for patients with the following conditions (absolute contraindications):

(A) Metabolic bone disease – for example, osteoporosis;

(B) Known spondyloarthropathy (seropositive and seronegative);

(C) Posttraumatic vertebral body deformity at the level of the proposed surgery;

(D) Malignancy of the spine;

(E) Implant allergy to the materials involved in the artificial disc;

(F) Pregnancy – currently;

(G) Active infection, local or systemic;

(H) Lumbar spondylolisthesis or lumbar spondylolysis;

(I) Prior fusion, laminectomy that involves any part of the facet joint, or facetectomy at the same level as proposed surgery; or

(J) Spinal stenosis – lumbar – moderate to severe lateral recess and central stenosis.

(b) Lumbar artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(g) may be inappropriate for patients with the following conditions, depending on severity, location, etc. (relative contraindications):

(A) A comorbid medical condition compromising general health, for example, hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS, lupus, etc.;

(B) Arachnoiditis;

(C) Corticosteroid use (chronic ongoing treatment with adrenal immunosuppression);

(D) Facet arthropathy – lumbar – moderate to severe, as shown radiographically;

(E) Morbid obesity – BMI greater than 40;

(F) Multilevel degenerative disc disease – lumbar – moderate to severe, as shown radiographically;

(G) Osteopenia – based on bone density test;

(H) Prior lumbar fusion at a different level than the proposed artificial disc replacement; or

(I) Psychosocial disorders – diagnosed as significant to severe.

(16) Cervical Artificial Disc Replacement Guidelines.

(a) Cervical artificial disc replacement is always inappropriate for patients with any of the following conditions (absolute contraindications):

(A) Instability in the cervical spine which is greater than 3.5 mm of anterior motion or greater than 20 degrees of angulation;

(B) Significantly abnormal facets;

(C) Osteoporosis defined as a T-score of negative (-)2.5 or more negative (e.g., -2.7);

(D) Allergy to metal implant;

(E) Bone disorders (any disease that affects the density of the bone);

(F) Uncontrolled diabetes mellitus;

(G) Active infection, local or systemic;

(H) Active malignancy, primary or metastatic;

(I) Bridging osteophytes (severe degenerative disease);

(J) A loss of disc height greater than 75 percent relative to the normal disc above;

(K) Chronic indefinite corticosteroid use;

(L) Prior cervical fusion at two or more levels; or

(M) Pseudo-arthrosis at the level of the proposed artificial disc replacement.

(b) Cervical artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(h) may be inappropriate for patients with any of the following conditions, depending on severity, location, etc. (relative contraindications):

(A) A comorbid medical condition compromising general health, for example hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS, lupus, etc.;

(B) Multilevel degenerative disc disease – cervical – moderate to severe, as shown radiographically;

(C) Osteopenia – based on bone density test with a T-score range of negative (-)1.5 to negative (-)2.5;

(D) Prior cervical fusion at one level;

(E) A loss of disc height of 50 percent to 75 percent relative to the normal disc above; or

(F) Psychosocial disorders – diagnosed as significant to severe.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0240 Medical Records and Reporting Requirements for Medical Providers

(1) Medical Records and Reports.

(a) Medical providers must maintain records necessary to document the extent of medical services provided.

(b) All records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(c) Reports may be handwritten and must include all relevant or requested information such as the anticipated date of release to return to work, medically stationary date, etc.

(d) Diagnoses stated on all reports, including Form 827, must conform to terminology found in the appropriate International Classification of Disease (ICD).

(2) Diagnostic Studies.

When the director or the insurer requests original diagnostic studies, including but not limited to actual films, they must be forwarded to the director, the insurer, or the insurer's designee within 14 days of receipt of a written request.

(a) Diagnostic studies, including films, must be returned to the medical provider within a reasonable time.

(b) The insurer must pay a reasonable charge made by the medical provider for the costs of delivery of diagnostic studies, including films.

(3) Multidisciplinary Programs.

When an attending physician or authorized nurse practitioner approves a multidisciplinary treatment program for the worker, the attending physician or authorized nurse practitioner must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.

(4) Release of Medical Records.

(a) Health Insurance Portability and Accountability Act (HIPAA) rules allow medical providers to release information to insurers, self-insured employers, service companies, or the Department of Consumer and Business Services. [See 45 CFR 164.512(l).]

(b) When patients file workers' compensation claims they are authorizing medical providers and other custodians of claim records to release relevant medical records including diagnostics. The medical provider will not incur any legal liability for disclosing such records. [See ORS 656.252(4).] The authorization is valid for the life of the claim and cannot be revoked by the patient or the patient's representative. A separate authorization is required for release of information regarding:

(A) Federally funded drug and alcohol abuse treatment programs governed by Federal Regulation 42, CFR 2, which may only be obtained in compliance with this federal regulation, and

(B) HIV-related information protected by ORS 433.045.

(c) Any medical provider must provide all relevant information to the director, or the insurer or its representative upon presentation of a signed Form 801, 827, or 2476. The insurer may print "Signature on file" on a release form as long as the insurer maintains a signed original. However, the medical provider may require a copy of the signed release form.

(d) The medical provider must respond within 14 days of receipt of a request for progress reports, narrative reports, diagnostic studies, or relevant medical records needed to review the efficacy, frequency, and necessity of medical treatment or medical services. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part.

(e) Patients or their representatives are entitled to copies of all medical and payment records, which may include records from other medical providers. Patients or their representatives may request all or part of the record. These records should be requested from the insurer, but may also be obtained from medical providers. A summary may substitute for the actual record only if the patient agrees to the substitution. The following records may be withheld:

(A) Psychotherapy notes;

(B) Information compiled for use in a civil, criminal, or administrative action or proceeding;

(C) Other reasons specified by federal regulation; and

(D) Information that was obtained from someone other than a medical provider when the medical provider promised confidentiality and release of the information would likely reveal the source of the information.

(f) A medical provider may charge the patient or his or her representative for copies at the rate specified in OAR 436-009-0060. A patient may not be denied summaries or copies of his or her medical records because of inability to pay.

(5) Release to Return to Work.

(a) When requested by the insurer, the attending physician or authorized nurse practitioner must submit verification that the patient's medical limitations related to their ability to work result from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return-to-work form, the insurer must use Form 3245.

(b) The attending physician or authorized nurse practitioner must advise the patient, and within five days, provide the insurer written notice of the date the patient is released to return to regular or modified work.

(6) Time Loss and Medically Stationary.

(a) When time loss is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report.

The provider must submit a requested progress report or narrative report within 14 days of receiving the insurer's request.

(b) The attending physician or authorized nurse practitioner must, if known, inform the patient and the insurer of the following and include it in each progress report:

(A) The anticipated date of release to work;

(B) The anticipated date the patient will become medically stationary;

(C) The next appointment date; and

(D) The patient's medical limitations.

(c) The insurer must not consider the anticipated date of becoming medically stationary as a date of release to return to work.

(d) The attending physician or authorized nurse practitioner must notify the patient, insurer, and all other medical providers involved in the patient's treatment when the patient is determined medically stationary and whether the patient is released to any kind of work. The medically stationary date must be the date of the exam and not a projected date.

(7) Consultations.

When the attending physician, authorized nurse practitioner, or the MCO requests a consultation with a medical provider regarding conditions related to an accepted claim:

(a) The attending physician, authorized nurse practitioner, or the MCO must promptly notify the insurer of the request for the consultation and provide the consultant with all relevant medical records. However, if the consultation is for diagnostic studies performed by radiologists or pathologists, no such notification is required.

(b) The consultant must submit a copy of the consultation report to the insurer and the attending physician, authorized nurse practitioner, or MCO within 10 days of the date of the exam or chart review. The consultation fee includes the fee for this report.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.245, 656.252, 656.254
Hist: Amended 3/7/16 as Admin. Order 16-051, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0241 Form 827, Worker's and Health Care Provider's Report for Workers' Compensation Claims

(1) First Visit.

(a) When the patient has filed an initial claim or wants to file an initial claim, the patient and the first medical service provider must complete and sign Form 827. The provider must send the form to the insurer no later than 72 hours after the patient's first visit (Saturdays, Sundays, and holidays are not counted in the 72-hour period).

(b) Form 3283 ("A Guide for Workers Recently Hurt on the Job") is included with Form 827. All medical service providers must give a copy of Form 3283 and Form 827 to the patient.

(2) New or Omitted Medical Condition.

A patient may use Form 827 to request that the insurer formally accept a new or omitted medical condition. If the patient uses the form to request acceptance of a new or omitted medical condition during a medical visit, the medical service provider may write the claimed condition or the appropriate International Classification of Diseases (ICD) diagnosis code for the patient in the space provided on the form. After the patient signs the form, the provider must send it to the insurer within five days.

(3) Change of Attending Physician.

When the patient changes attending physician or authorized nurse practitioner, the patient and the new medical service provider must complete and sign Form 827. The provider must send Form 827 to the insurer within five days after becoming a patient's attending physician or authorized nurse practitioner. The new attending physician or authorized nurse practitioner is responsible for requesting all available medical records from the previous attending physician, authorized nurse practitioner, or insurer. Anyone failing to forward the requested information to the new attending physician or authorized nurse practitioner within 14 days of receiving the request may be subject to sanctions under OAR 436-010-0340.

(4) Aggravation.

After the patient has been declared medically stationary, and an exam reveals an aggravation of the patient's accepted condition, the patient may file a claim for aggravation. The patient or the patient's representative and the attending physician must complete and sign Form 827. The physician, on the patient's behalf, must submit Form 827 to the insurer within five days of the exam. Within 14 days of the exam, the attending physician must send a written report to the insurer that includes objective findings that document:

(a) Whether the patient has suffered a worsened condition attributable to the compensable injury under the criteria in ORS 656.273; and

(b) Whether the patient is unable to work as a result of the compensable worsening.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.245, 656.252, 656.254, 656.273
Hist: Adopted 8/20/15 as Admin. Order 15-060, eff. 10/1/15

436-010-0250 Elective Surgery

(1) "Elective surgery" is surgery that may be required to recover from an injury or illness, but is not an emergency surgery to preserve life, function, or health.

(2) Except as otherwise provided by the MCO, the attending physician, authorized nurse practitioner, or specialist physician must give the insurer at least seven days notice before the date of the proposed elective surgery to treat a compensable injury or illness. The notice must provide the medical information that substantiates the need for surgery, and the approximate surgical date and place if known. A chart note is considered

"notice" if the information required by this section is included in the note.

(3) When elective surgery is proposed, the insurer may require an independent consultation (second opinion) with a physician of the insurer's choice.

(4) The insurer must respond to the recommending physician, the worker, and the worker's representative within seven days of receiving the notice of intent to perform surgery that the proposed surgery:

(a) Is approved;

(b) Is not approved and a consultation is requested by using Form 3228 (Elective Surgery Notification); or

(c) Is disapproved by using Form 3228.

(5) If the insurer does not complete Form 3228 (e.g., no specific date or consultant name) or communicate approval to the recommending physician within seven days of receiving the notice of intent to perform surgery, the insurer is barred from challenging the appropriateness of the surgery or whether the surgery is excessive or ineffectual. The attending physician and the worker may decide whether to proceed with surgery.

(6) If the insurer requests a consultation, it must be completed within 28 days after sending Form 3228 to the physician.

(7) The insurer must notify the recommending physician of the consultant's findings within seven days of the consultation.

(8) When the consultant disagrees with the proposed surgery, the recommending physician and insurer should attempt to resolve disagreement. The insurer and recommending physician may agree to obtain additional diagnostic testing or other medical information, such as asking for clarification from the consultant, to assist in reaching an agreement regarding the proposed surgery.

(9) If the recommending physician cannot reach an agreement with the insurer and continues to recommend the proposed surgery, the physician must either send the signed and dated Form 3228 or other written notification to the insurer, the patient, and the patient's representative. If the insurer believes the proposed surgery is excessive, inappropriate, ineffectual, or in violation of these rules, the insurer must request administrative review before the director within 21 days of receiving the notification. If the insurer fails to timely request administrative review the insurer is barred from challenging whether the surgery is or was excessive, inappropriate, or ineffectual. The attending physician and the worker may decide whether to proceed with surgery.

(10) A recommending physician who prescribes or performs elective surgery and fails to give the insurer the seven day notice requirement may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340. The insurer may still be responsible to pay for the elective surgery.

(11) Surgery that must be performed before seven days, because the condition is life threatening or there is rapidly progressing deterioration or acute pain not manageable without surgical intervention, is not considered elective surgery. In such cases, the attending physician or authorized nurse practitioner should try to notify the insurer of the need for emergency surgery.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.260, 656.327
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0265 Independent Medical Exams (IMEs) and Worker Requested Medical Exams (WRMEs)

(1) General.

(a) Except as provided in section (12) of this rule, "independent medical exam" (IME) means any medical exam (including a physical capacity or work capacity evaluation or consultation that includes an exam) that is requested by the insurer under ORS 656.325. A "worker-requested medical exam" (WRME) is an exam available to a worker under ORS 656.325. An IME or WRME is completed by a medical service provider other than the worker's attending physician or authorized nurse practitioner. The insurer may obtain three IMEs for each opening of the claim. These exams may be obtained before or after claim closure. For the purpose of determining the number of IMEs, any IME scheduled but not completed does not count as a statutory IME. A claim for aggravation, Board's Own Motion, or reopening of a claim when the worker becomes enrolled or actively engaged in training according to rules adopted under ORS 656.340 and 656.726 allows a new series of three IMEs. A medical service provider must not unreasonably interfere with the right of the insurer to obtain an IME by a physician of the insurer's choice. The insurer must choose the medical service providers from the director's list of authorized IME providers under ORS 656.328. The IME may be conducted by one or more providers of different specialties, generally done at one location and completed within a 72-hour period. If the providers are not at one location, the IME must be completed within a 72-hour period and at locations reasonably convenient to the worker.

(b) The provider will determine the conditions under which the exam will be conducted.

(c) IMEs must be at times and intervals reasonably convenient to the worker and must not delay or interrupt treatment of the worker.

(d) When the insurer requires a worker to attend an IME, the insurer must comply with the notification and reimbursement requirements found in OAR 436-009-0025 and 436-060-0095.

(e) A medical provider who unreasonably fails to provide diagnostic records for an IME under OAR 436-010-0240 may be assessed a penalty under ORS 656.325.

(f) The worker may complete an online survey at www.wcdimesurvey.info or make a complaint about the IME on the Workers' Compensation Division's website. If the worker does not have access to the Internet, the worker may call the Workers' Compensation Division at 503-947-7606.

(2) IME/WRME Authorization.

(a) Medical service providers can perform IMEs, WRMEs, or both once they complete a director-approved training and are placed on the director's list of authorized IME providers.

(A) To be on the director's list to perform IMEs or WRMEs, a medical service provider must complete the online application at www.oregonwcdoc.info, hold a current license, be in good standing with the provider's regulatory board, and must have:

(i) Reviewed IME training materials provided or approved by the director found at www.oregonwcdoc.info; or

(ii) Completed a director-approved training course regarding IMEs. The training curriculum must include all topics listed in Appendix B.

(B) By submitting the application to the director, the medical service provider agrees to abide by:

(i) The standards of professional conduct for performing IMEs adopted by the provider's regulatory board or standards published in Appendix C if the provider's regulatory board does not have standards; and

(ii) All relevant workers' compensation laws and rules.

(C) A provider may be sanctioned or removed from the director's list of authorized IME providers after the director finds that the provider:

(i) Violated the standards of either the professional conduct for performing IMEs adopted by the provider's regulatory board or the independent medical examination standards published in Appendix C;

(ii) Has a current restriction on his or her license or is under a current disciplinary action from their professional regulatory board;

(iii) Has entered into a voluntary agreement with his or her regulatory board that the director determines is detrimental to performing IMEs;

(iv) Violated workers' compensation laws or rules; or

(v) Has failed to complete training required by the director.

(D) A provider may appeal the director's decision to exclude or remove the provider from the director's list within 60 days under ORS 656.704(2) and OAR 436-001-0019.

(b) If a provider is not on the director's list of authorized IME providers at the time of the IME, the insurer may not use the IME report and the report may not be used in any subsequent proceedings.

(3) IME Training.

(a) The IME provider training curriculum must be approved by the director before the training is given. Any party may submit a curriculum to the director for approval. The curriculum must include:

(A) A training outline,

(B) Goals,

(C) Objectives,

(D) The method of training, and

(E) All topics addressed in Appendix B.

(b) Within 21 days of the IME training, the training vendor must send the director the date of the training and a list of all medical providers who completed the training, including names and license numbers.

(c) Insurer claims examiners must be trained and certified in accordance with OAR 436-055 regarding appropriate interactions with IME medical service providers.

(4) IME Related Forms.

(a) When scheduling an IME, the insurer must ensure the medical service provider has:

(A) Form 3923, "Important Information about Independent Medical Exams," available to the worker before the exam; and

(B) Form 3227, "Invasive Medical Procedure Authorization," if applicable.

(b) The IME provider must make Form 3923 with the attached observer Form 3923A available to the worker.

(5) IME Observer.

(a) A worker may choose to have an observer present during the IME, however, an observer may not participate in or obstruct the IME. An observer is not allowed in a psychological examination unless the examining provider approves the presence of the observer.

(b) The worker must sign Form 3923A, "IME Observer Form," acknowledging that the worker understands the IME provider may ask sensitive questions during the exam in the presence of the observer. An observer must not participate in or obstruct the exam. If the worker does not sign Form 3923A, the provider may exclude the observer. The IME provider must verify that the worker signed the "IME Observer Form" acknowledging that the worker understands:

(A) The IME provider may ask sensitive questions during the exam in the presence of the observer;

(B) If the observer interferes with the exam, the IME provider may stop the exam, which could affect the worker's benefits; and

(C) The observer must not be paid to attend the exam.

(c) A person receiving any compensation for attending the exam may not be a worker's observer. The worker's attorney or any representative of the worker's attorney may not be an observer.

(6) Invasive Procedure.

For the purposes of this rule, an invasive procedure is one that breaks the skin or penetrates, pierces, or enters the body using a surgical or exploratory procedure (e.g., by a needle, tube, scope, or scalpel). If an IME provider intends to perform an invasive procedure, the provider must explain to the worker the risks involved in the procedure and the worker's right to refuse the procedure. The worker must check the applicable box on Form 3227, "Invasive Medical Procedure Authorization," either agreeing to the procedure or declining the procedure and sign the form.

(7) Record the Exam.

With the IME provider's approval, the worker may use a video camera or other recorder to record the exam.

(8) Objection to the IME Location.

When a worker objects to the location of an IME, the worker may request review before the director within six business days of the mailing date of the appointment notice.

(a) The request may be made in-person, by telephone, fax, email, or mail.

(b) The director may facilitate an agreement between the parties regarding location.

(c) If necessary, the director will conduct an expedited review and issue an order regarding the reasonableness of the location.

(d) The director will determine if travel is medically contraindicated or unreasonable because:

(A) The travel exceeds limitations imposed by the attending physician, authorized nurse practitioner, or any medical conditions;

(B) Alternative methods of travel will not overcome the limitations; or

(C) The travel would impose undue hardship for the worker that outweighs the right of the insurer to select an IME location of its choice.

(9) Failure to Attend an IME.

If the worker fails to attend an IME and does not notify the insurer before the date of the exam or does not have sufficient reason for not attending the exam, the director may impose a monetary penalty against the worker for failure to attend.

(10) IME Report.

(a) Upon completion of the exam, the IME provider must:

(A) Send the insurer a copy of the report and, if applicable, the observer Form 3923A, the invasive procedure Form 3227, or both.

(B) Sign a statement at the end of the report acknowledging that any false statements may result in sanctions by the director and verifying:

(i) Who performed the exam;

(ii) Who dictated the report; and

(iii) The accuracy of the report content.

(b) The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within three days, excluding weekends and legal holidays, of the insurer's receipt of the report.

(11) Request for Additional Exams.

(a) When the insurer has obtained the three IMEs allowed under this rule and wants to require the worker to attend an additional IME, the insurer must first request authorization from the director. Insurers that fail to request authorization from the director may be assessed a civil penalty. The process for requesting authorization is:

(A) The insurer must submit a request for authorization to the director by using Form 2333, "Insurer's Request for Director Approval of an Additional Independent Medical Examination." The insurer must send a copy of the request to the worker and the worker's attorney, if any; and

(B) The director will review the request and determine if additional information from the insurer or the worker is necessary. Upon receiving a written request for additional information from the director, the parties have 14 days to respond. If the parties do not provide the requested information, the director will issue an order approving or disapproving the request based on available information.

(b) To determine whether to approve or deny the request for an additional IME, the director may consider, but is not limited to, whether:

(A) An IME involving the same discipline(s) or review of the same condition has been completed within the past six months.

(B) There has been a significant change in the worker's condition.

(C) There is a new condition or compensable aspect introduced to the claim.

(D) There is a conflict of medical opinions about a worker's medical treatment, medical services, impairment, stationary status, or other issues critical to claim processing or benefits.

(E) The IME is requested to establish preponderance for medically stationary status.

(F) The IME is medically harmful to the worker.

(G) The IME requested is for a condition for which the worker has sought treatment or services, or the condition has been included in the compensable claim.

(c) Any party who disagrees with the director's order approving or disapproving a request for an additional IME may request a hearing by the Hearings Division of the Workers' Compensation Board under ORS 656.283 and OAR chapter 438.

(12) Other Exams – Not Considered IMEs.

The following exams are not considered IMEs and do not require approval as outlined in section (11) of this rule:

(a) An exam, including a closing exam, requested by the worker's attending physician or authorized nurse practitioner;

(b) An exam requested by the director;

(c) An elective surgery consultation requested under OAR 436-010-0250(3);

(d) An exam of a permanently totally disabled worker required under ORS 656.206(5);

(e) A closing exam that has been arranged by the insurer at the attending physician's or authorized nurse practitioner's request; and

(f) An exam requested by the managed care organization (MCO) for the purpose of clarifying or refining a plan for continuing medical services as provided under the MCO's contract.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Amended 3/7/16 as Admin. Order 16-051, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0270 Insurer's Rights and Duties

(1) Notifications.

(a) Immediately following receipt of notice or knowledge of a claim, the insurer must notify the worker in writing about how to receive medical services for compensable injuries.

(b) Within 10 days of any change in the status of a claim, (e.g., acceptance or denial of a claim, or a new or omitted medical condition), the insurer must notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any.

(c) In disabling and nondisabling claims, immediately following notice or knowledge that the worker is medically stationary, the insurer must notify the worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).

(d) When the insurer establishes a medically stationary date that is not based on the findings of an attending physician or authorized nurse practitioner, the insurer must notify all medical service providers of the worker's medically stationary status. For all injuries occurring on or after October 23, 1999, the insurer must pay all medical service providers for services rendered until the insurer provides notice of the medically stationary date to the attending physician or authorized nurse practitioner.

(2) Medical Records Requests.

(a) Insurers may request relevant medical records, using Form 2476, "Request for Release of Medical Records for Oregon Workers' Compensation Claim," or a computer-generated equivalent of Form 2476, with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

(b) Within 14 days of receiving a request, the insurer must forward all relevant medical information to return-to-work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner.

(3) Pre-authorization.

Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request for preauthorization of diagnostic imaging studies, other than plain film X-rays. The response must include whether the service is pre-authorized or not pre-authorized.

(4) Insurer's Duties under MCO Contracts.

(a) Insurers who enter into an MCO contract under OAR 436-015, must notify the affected employers of the following:

(A) The names and addresses of all MCO panel providers within the employer's geographical service area(s);

(B) How workers can receive compensable medical services within the MCO;

(C) How workers can receive compensable medical services by non-panel providers; and

(D) The geographical service area governed by the MCO.

(b) Insurers under contract with an MCO must notify any newly insured employers as specified in subsection (4)(a) of this rule no later than the effective date of coverage.

(c) When the insurer is enrolling a worker in an MCO, the insurer must provide the name, address, and telephone number of the worker and, if represented, the name of the worker's attorney to the MCO.

(d) When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical providers, and the MCO of enrollment. To be considered complete, the notice must:

(A) Provide the worker a written list of the eligible attending physicians within the relevant MCO geographic service area or provide a Web address to access the list of eligible attending physicians. If the notice does not include a written list, then the notice must also:

(i) Provide a telephone number the worker may call to ask for a written list; and

(ii) Tell the worker that he or she has seven days from the mailing date of the notice to request the list;

(B) Explain how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

(C) Advise the worker how to obtain medical services for compensable injuries within the MCO. This includes whether the worker:

(i) Must change attending physician or authorized nurse practitioner to an MCO panel provider, or

(ii) May continue to treat with the worker's current attending physician or authorized nurse practitioner;

(D) Explain how the worker can receive compensable medical treatment from a "come-along" provider;

(E) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer, except when the employer provides a coordinated health care program. For the purpose of this rule, "coordinated health care program" means an employer program providing coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides the workers with health care benefits even if a workers' compensation claim is denied; and

(F) Notify the worker of his or her right to appeal MCO decisions and provide the worker with the title, address, and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes.

(e) When an insurer enrolls a worker in an MCO before claim acceptance, the insurer must inform the worker in writing that the insurer will pay for certain medical services even if the claim is denied. Necessary and reasonable medical services that are not otherwise covered by health insurance will be paid until the worker receives the notice of claim denial or until three days after the denial is mailed, whichever occurs first.

(f) When a worker who is not yet medically stationary must change medical providers because an insurer enrolled the worker in an MCO, the insurer must notify the worker of the right to request review before the MCO if the worker believes the change would be medically detrimental.

(g) If, at the time of MCO enrollment, the worker's medical service providers are not members of the MCO and do not qualify as "come-along providers," the insurer must notify the worker and providers regarding provisions of care under the MCO contract, including continuity of care as provided by OAR 436-015-0035(4).

(h) Within seven days of receiving a dispute regarding an issue that should be processed through the MCO dispute resolution process and a copy has not been sent to the MCO, the insurer must:

(A) Send a copy of the dispute to the MCO; or

(B) If the MCO does not have a dispute resolution process for that issue, notify the parties in writing to seek administrative review before the director.

(i) The insurer must notify the MCO within seven days of receiving notification of the following:

(A) Any changes to the worker's or worker's attorney's name, address, or telephone number;

(B) Any requests for medical services from the worker or the worker's medical provider; or

(C) Any request by the worker to continue treating with a "come-along" provider.

(j) Insurers under contract with MCOs must maintain records including, but not limited to:

(A) A listing of all employers covered by MCO contracts;

(B) The employers' WCD employer numbers;

(C) The estimated number of employees governed by each MCO contract;

(D) A list of all workers enrolled in the MCO; and

(E) The effective dates of such enrollments.

(k) When the insurer is disenrolling a worker from an MCO, the insurer must simultaneously provide written notice of the disenrollment to the worker, the worker's representative, all medical service providers, and the MCO. The insurer must mail the notice no later than seven days before the date the worker is no longer subject to the contract. The notice must tell the worker how to obtain compensable medical services after disenrollment.

(l) When an MCO contract expires or is terminated without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days before the date the contract expires or terminates. The notice must tell the worker how to obtain compensable medical services after the worker is no longer subject to the MCO contract.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Amended 3/7/16 as Admin. Order 16-051, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0280 Determination of Impairment / Closing Exams

(1) When a worker has received compensation for time loss or it is likely the worker has permanent impairment and becomes medically stationary, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. If the worker is under the care of an authorized nurse practitioner or a type B attending physician, other than a chiropractic physician, the provider must refer the worker to a type A attending physician to do a closing exam.

(2) The closing exam must be completed under OAR 436-030 and 436-035 and Bulletin 239. (See Appendix A "Matrix for Health Care Provider Types".)

(3) When the attending physician completes the closing exam, the attending physician has 14 days from the medically stationary date to send the closing report to the insurer. When the attending physician does not complete the closing exam, the attending physician must arrange, or ask the insurer to arrange, a closing exam with a consulting physician within seven days of the medically stationary date.

(4) When an attending physician or authorized nurse practitioner requests a consulting physician to do the closing exam, the consulting physician has seven days from the date of the exam to send the report to the attending physician for concurrence or objections. Within seven days of receiving the closing exam report, the attending physician must state in writing whether the physician concurs with or objects to all or part of the findings of the exam, and send the concurrence or objections with the report to the insurer.

(5) The attending physician must specify the worker's residual functional capacity if:

(a) The attending physician has not released the worker to the job held at the time of injury because of a permanent work restriction caused by the compensable injury, and

(b) The worker has not returned to the job held at the time of injury, because of a permanent work restriction caused by the compensable injury.

(6) Instead of specifying the worker's residual functional capacity under section (5) of this rule, the attending physician may refer the worker for:

(a) A second-level physical capacities evaluation (see OAR 436-009-0060) when the worker has not been released to return to the job held at the time of injury, has not returned to the job held at the time of injury, has returned to modified work, or has refused an offer of modified work; or

(b) A work capacities evaluation (see OAR 436-009-0060) when there is a question of the worker's ability to return to suitable and gainful employment. The provider may also be required to specify the worker's ability to perform specific job tasks.

(7) When the insurer issues a major contributing cause denial on an accepted claim and the worker is not medically stationary:

(a) The attending physician must do a closing exam or refer the worker to a consulting physician for all or part of the closing exam; or

(b) An authorized nurse practitioner or a type B attending physician, other than a chiropractic physician, must refer the worker to a type A attending physician for a closing exam.

(8) The closing report must include all of the following:

(a) Findings of permanent impairment.

(A) In an initial injury claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury.

(B) In a new or omitted condition claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(C) In an aggravation claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(D) In an occupational disease claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(b) Findings documenting permanent work restrictions.

(A) If the worker has no permanent work restriction, the closing report must include a statement indicating that:

(i) The worker has no permanent work restriction; or

(ii) The worker is released, without restriction, to the job held at the time of injury.

(B) In an initial injury claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury.

(C) In a new or omitted condition claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(D) In an aggravation claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(E) In an occupational disease claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted occupational disease or a direct medical sequel of an accepted occupational disease.

(c) A statement regarding the validity of an impairment finding is required in the following circumstances:

(A) If the examining physician determines that a finding of impairment is invalid, the closing report must include a statement that identifies the basis for the determination that the finding is invalid.

(B) If the examining physician determines that a finding of impairment is valid but the finding is not addressed by any applicable validity criteria under Bulletin 239, the closing report must include a statement that identifies the basis for the determination that the finding is valid.

(C) If the examining physician chooses to disregard applicable validity criteria under Bulletin 239 because the criteria are medically inappropriate for the worker, the closing report must include a statement that describes why the criteria would be inappropriate.

Stat. Auth: ORS 656.726(4), 656.245(2)(b)
Stats. Implemented: ORS 656.245, 656.252
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0290 Medical Care After Medically Stationary

(1) A worker is found medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. Medical services after a worker's condition is medically stationary are compensable only when services are:

(a) Palliative care under section (2) of this rule;

(b) Curative care under sections (3) and (4) of this rule;

(c) Provided to a worker who has been determined permanently and totally disabled;

(d) Prescription medications;

(e) Necessary to administer or monitor administration of prescription medications;

(f) Prosthetic devices, braces, or supports;

(g) To monitor the status of, to replace, or to repair prosthetic devices, braces, and supports;

(h) Provided under an accepted claim for aggravation;

(i) Provided under Board's Own Motion;

(j) Necessary to diagnose the worker's condition; or

(k) Life-preserving modalities similar to insulin therapy, dialysis, and transfusions.

(2) Palliative Care.

(a) Palliative care means that medical services are provided to temporarily reduce or moderate the intensity of an otherwise stable medical condition. It does not include those medical services provided to diagnose, heal, or permanently alleviate or eliminate a medical condition. Palliative care is compensable when the attending physician prescribes it and it is necessary to enable the worker to continue current employment or a vocational training program. Before palliative care can begin, the attending physician must submit a written palliative care request to the insurer for approval. The request must:

(A) Describe any objective findings;

(B) Identify the medical condition for which palliative care is requested by the appropriate ICD diagnosis;

(C) Detail a treatment plan which includes the name of the provider who will provide the care, specific treatment modalities, and frequency and duration of the care, not to exceed 180 days;

(D) Explain how the requested care is related to the compensable condition; and

(E) Describe how the requested care will enable the worker to continue current employment, or a current vocational training program, and the possible adverse effect if the care is not approved.

(b) Palliative care may begin after the attending physician submits the request to the insurer. If the insurer approves the request, palliative care services are payable from the date service begins. However, if the request is ultimately disapproved, the insurer is not liable for payment of the palliative care services.

(c) Insurers must date stamp all palliative care requests upon receipt. Within 30 days of receiving the request, the insurer must send written notice to the attending physician, worker, and worker's attorney approving or disapproving the request.

(d) If the insurer disapproves the request, the insurer must explain the reason why in writing. Reasons to disapprove a palliative care request may include:

(A) The palliative care services are not related to the accepted condition(s);

(B) The palliative care services are excessive, inappropriate, or ineffectual; or

(C) The palliative care services will not enable the worker to continue current employment or a current vocational training program.

(e) When the insurer disapproves the palliative care request, the attending physician or the worker may request administrative review before the director under OAR 436-010-0008. The request for review must be within 90 days from the date of the insurer's disapproval notice. In addition to information required by OAR 436-010-0008, if the request is from the attending physician, it must include:

(A) A copy of the original request to the insurer; and

(B) A copy of the insurer's response.

(f) If the insurer fails to respond to the request in writing within 30 days, the attending physician or worker may request approval from the director within 120 days from the date the request was first submitted to the insurer. When the attending physician requests approval from the director, the physician must include a copy of the original request and may include any other supporting information.

(g) Subsequent requests for palliative care are subject to the same process as the initial request; however, the insurer may waive the requirement that the attending physician submit a supplemental palliative care request.

(3) Curative Care.

Curative medical care is compensable when the care is provided to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition.

(4) Advances in Medical Science.

The director must approve curative care arising from a generally recognized, nonexperimental advance in medical science since the worker's claim was closed that is highly likely to improve the worker's condition and that is otherwise justified by the circumstances of the claim. When the attending physician believes that curative care is appropriate, the physician must submit a written request for approval to the director. The request must:

(a) Describe any objective findings;

(b) Identify the appropriate ICD diagnosis (the medical condition for which the care is requested);

(c) Describe in detail the advance in medical science that has occurred since the worker's claim was closed that is highly likely to improve the worker's condition;

(d) Provide an explanation, based on sound medical principles, as to how and why the care will improve the worker's condition; and

(e) Describe why the care is otherwise justified by the circumstances of the claim.

Stat. Auth: ORS 656.726
Stats. Implemented: ORS 656.245
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0300 Requesting Exclusion of Medical Treatment from Compensability

If a worker or insurer believes that any medical treatment is unscientific, unproven as to its effectiveness, outmoded, or experimental, either party may initiate a request for exclusion of the medical treatment from compensability under ORS 656.245(3). The request must include documentation on why the medical treatment should be excluded from compensability for workers' compensation claims. The director will request advice from the licensing boards of practitioners that might be affected and the Medical Advisory Committee. The director will issue an order and may adopt a rule declaring the treatment to be noncompensable. The decision of the director

is appealable under ORS 656.704. Request for administrative review of an individual worker's treatment under ORS 656.327 does not initiate review under this process. Excluded treatments are listed in OAR 436-009-0010.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0330 Medical Arbiters and Physician Reviewers

(1) The director will establish and maintain a list of arbiters. The director will appoint a medical arbiter or a panel of medical arbiters from this list under ORS 656.268.

(2) The director will establish and maintain a list of physician reviewers. The director will appoint an appropriate physician or a panel of physicians from this list to review medical treatment or medical services disputes under ORS 656.245 and 656.327.

(3) When a worker is required to attend an examination under this rule, the director will provide notice of the examination to the worker and all affected parties. The notice will inform all parties of the time, date, location, and purpose of the examination. Examinations will be at a place reasonably convenient to the worker, if possible.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.268, 656.325, 656.327
Hist: Amended 3/7/16 as Admin. Order 16-051, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0335 Monitoring and Auditing Medical Providers

(1) The director may monitor and conduct periodic audits of medical providers to ensure compliance with ORS chapter 656 and chapter 436 of the administrative rules.

(2) All records maintained or required to be maintained must be disclosed upon request of the director.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.245, 656.254, 656.745
Hist: Amended and renumbered from OAR 436-010-0260 8/20/15 as Admin. Order 15-060, eff. 10/1/15

436-010-0340 Sanctions and Civil Penalties

(1) If the director finds any medical provider in violation of the medical reporting requirements established under ORS 656.245, 656.252, 656.254(1), or 656.325, or OAR 436-009 or 436-010, the director may impose one or more of the following sanctions:

(a) Reprimand by the director;

(b) Non-payment, reduction, or recovery of fees in part or whole for medical services provided;

(c) Referral to the appropriate licensing board;

(d) Civil penalty not to exceed $1,000 for each occurrence. In determining the amount of penalty to be assessed, the director will consider:

(A) The degree of harm inflicted on the worker or the insurer;

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violations; or

(e) A penalty of $100 for each violation of ORS 656.325(1)(c)(C).

(2) If the medical provider fails to provide information under OAR 436-010-0240 within fourteen days of receiving a request sent by certified mail or fax, penalties under this rule or OAR 436-015-0120 may be imposed.

(3) The director may impose a penalty of forfeiture of fees and a fine not to exceed $1,000 for each occurrence on any medical service provider who, under ORS 656.254, and 656.327, has been found to:

(a) Fail to comply with the medical rules;

(b) Provide medical services that are excessive, inappropriate, or ineffectual; or

(c) Engage in any conduct demonstrated to be dangerous to the health or safety of a worker.

(4) If the conduct as described in section (3) of this rule is found to be repeated and willful, the director may declare the medical provider ineligible for reimbursement for treating workers' compensation patients for a period not to exceed three years.

(5) A medical provider whose license has been suspended or revoked by the licensing board for violations of professional ethical standards may be declared ineligible for reimbursement for treating workers' compensation patients for a period not to exceed three years. A certified copy of the revocation or suspension order will be prima facie justification for the director's order.

(6) If a financial penalty is imposed on the medical provider for violation of these rules, the provider may not seek recovery of the penalty fees from the worker.

(7) If an insurer or worker believes sanctions under sections (1) or (2) of this rule are appropriate, either may submit a complaint in writing to the director.

(8) If the director finds an insurer in violation of the notification provisions of OAR 436-010 limiting medical services, the director may order the insurer to reimburse any affected medical providers for services provided until the insurer complies with the notification requirement. Any penalty will be limited to the amounts listed in section (9) of this rule.

(9) If the director finds any insurer in violation of statute, OAR 436-009, OAR 436-010, or an order of the director, the insurer may be subject to penalties under ORS 656.745 of not more than $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, will be considered a separate violation.

(10) The director may subject a worker who fails to meet the requirements in OAR 436-010-0265(9) to a $100 penalty per occurrence under ORS 656.325, to be deducted from future benefits.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.245, 656.254, 656.745
Hist: Amended 3/7/16 as Admin. Order 16-051, eff. 4/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

Appendix A - Matrix for health care provider types *

See OAR 436-010-0005

	Attending physician status (primarily responsible for treatment of a patient's injury)	Provide compensable medical services for initial injury or illness	Authorize payment of time loss (temporary disability) and release the patient to work	Establish impairment findings (permanent disability)	Provide compensable medical services for aggravation of injury or illness
Type A attending physician Medical doctor Doctor of osteopathy Oral and maxillofacial surgeon Podiatric physician and surgeon	Yes	Yes	Yes	Yes	Yes
Type B attending physician Chiropractic physician Naturopathic physician Physician assistant	Yes, for a total of 60 consecutive days or 18 visits, from the date of the initial visit on the initial claim with any Type B attending physician.	Yes, unless the total of 60 consecutive days or 18 visits from the date of the initial visit on the initial claim with any Type B attending physician has passed. Or, if authorized by an attending physician and under a treatment plan.	Yes, 30 days from the date of the first visit with any type B attending physician on the initial claim, if within the specified 18 visit period.	No, unless the type B attending physician is a chiropractic physician.	No Unless authorized by attending physician and under a written treatment plan (Note: physician assistants are not required to have a written treatment plan)
Emergency room physicians	No, if the physician refers the patient to a primary care physician	Yes	ER physicians may authorize time loss for up to 14 days only, including retroactive authorization	No if patient referred to a primary care physician	Yes
Authorized nurse practitioner	No	Yes, for 180 consecutive days from the date of the first visit to any authorized nurse practitioner on the initial claim. Or if authorized by attending physician.	Yes, for 180 days from the date of the first visit on the initial claim.	No	No Unless authorized by the attending physician
Other health care providers e.g., acupuncturists	No	Yes, for 30 consecutive days or 12 visits from the date of the first visit on the initial claim with any other health care providers. Thereafter, services must be provided under a treatment plan and authorized by the attending physician.	No	No	No, unless referred by the attending physician and under a written treatment plan

* This matrix does not apply to Managed Care Organizations

Appendix B

Independent Medical Examination (IME) Medical Service Provider Training Curriculum Requirements

A. Overview
WCD will provide the overview portion of the curriculum to vendors for use in their approved training program.

1. Why the IME training is required.
   a) The Workers' Compensation Management-Labor Advisory Committee requested a study after hearing anecdotal injured worker complaints.
   b) The Workers' Compensation Division (WCD) study found there was perceived bias in the IME system.
   c) There was no process to handle complaints about IMEs.
   d) There was concern about IME report quality.
   e) The 2005 Legislature passed Senate Bill 311 unanimously.

2. Workers' compensation system:
   a) Public policy: workers' compensation law [ORS 656.012 (2)] identifies four objectives:
      1) Provide, regardless of fault, sure, prompt and complete medical treatment for injured workers, and fair, adequate, and reasonable income benefits to injured workers and their dependents.
      2) Provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent possible.
      3) Restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable.
      4) Encourage maximum employer implementation of accident study, analysis and prevention programs to reduce the economic loss and human suffering caused by industrial accidents.

      Additional items to discuss:
      - Exclusive remedy.
      - The Legislature found that common law is expensive without proportionate benefit.
      - No fault versus tort.
      - The economy and the costs of injuries.

   b) Causation of work related injuries.
      - Is the injury work related?
      - What are pre-existing conditions?
      - What is major contributing cause?
      - What is material contributing cause?

   c) The IME provider role
      - Unbiased, neutral third-party
      - Independent

   d) The difference between IMEs and
      - Worker Requested Medical Exams (Causation)
      - Arbiter Exams (Reconsideration)
      - Physician Reviews (Medical disputes)

B. Provider Code of Professional Conduct
IME providers must follow a professional standard or guidelines of conduct while performing IMEs. The guidelines must be:
1. The guidelines adopted by the appropriate health professional regulatory board, OR
2. The "Guidelines of Conduct" published in Appendix C, if the appropriate regulatory board hasn't adopted standards for professional conduct regarding IMEs.

C. Report writing
1. The statement of accuracy must be in compliance with OAR 436-010-0265.
2. Report content: what comprises a good IME report?

D. Communication
What is appropriate communication between claims examiners and medical providers?

E. Training specific to the requirements of ORS 656.325, OAR 436-010, and 436-060 concerning:
1. Observers
2. Recording of exams
3. Invasive procedures
4. Sanctions and civil penalties
5. Worker penalties and suspension
6. Exam location disputes
7. Forms
8. Complaints.

F. Sanctions of providers, up to and including removal from the list:
1. Provider has restrictions on its license or current disciplinary actions from its health professional regulatory board.
2. Provider has entered into a voluntary agreement with the licensing board that the director has determined to be detrimental to performing IMEs.
3. Provider has violated the standards of professional conduct for IMEs.
4. Provider has violated workers' compensation laws or rules.
5. Provider has failed to attend training required by the director.

G. If the director removes a provider's name from the director's list, providers may appeal.

H. Workers' Compensation Division's complaint process:
1. Use of injured workers surveys about IMEs
2. Complaints received by the Workers' Compensation Division.

I. Impairment findings: The purpose of measuring impairment is vital to accurately report return-to-work status using job description, job analysis, work capacities, video of the job at injury being performed, etc.

J. Other necessary information as determined by the director.

OAR 436-010-0265

Appendix C

Independent Medical Examination Standards
As developed by the Independent Medical Examination Association

1. Communicate honestly with the parties involved in the examination.
2. Conduct the examination with dignity and respect for the parties involved.
3. Identify yourself to the examinee as an independent examining physician.
4. Verify the examinee's identity.
5. Discuss the following with the examinee before beginning the examination:
   a. Remind the examinee of the party who requested the examination.
   b. Explain to the examinee that a physician-patient relationship will not be sought or established.
   c. Tell the examinee the information provided during the examination will be documented in a report.
   d. Review the procedures that will be used during the examination.
   e. Advise the examinee a procedure may be terminated if the examinee feels the activity is beyond the examinee's physical capacities or when pain occurs.
   f. Answer the examinee's questions about the examination process.
6. During the examination:
   a. Ensure the examinee has privacy to disrobe.
   b. Avoid personal opinions or disparaging comments about the parties involved in the examination.
   c. Examine the condition being evaluated sufficient to answer the requesting party's questions.
   d. Let the examinee know when the examination has concluded, and ask if the examinee has questions or wants to provide additional information.
7. Provide the requesting party a timely report that contains findings of fact and conclusions based on medical probabilities for which the physician is qualified to express an opinion.
8. Maintain the confidentiality of the parties involved in the examination subject to applicable laws.
9. At no time provide a favorable opinion based solely or in part upon an accepted fee for service.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 015

MANAGED CARE ORGANIZATIONS

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436-015-0001 Authority For Rules

These rules are promulgated under the director's general rule-making authority of ORS 656.726 (4) and specific authority under ORS 656.245, 656.248, 656.252, 656.254, 656.260, 656.268, 656.325, 656.327, and 656.794.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: Amended 2/25/02, as Admin. Order 02-053, eff. 4/1/02
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0002 Purpose

The purpose of these rules is to establish and provide policies, procedures, and requirements for the administration, evaluation, and enforcement of the statutes relating to the delivery of medical services by managed care organizations (MCOs) to injured workers within the workers' compensation system.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0003 Applicability of Rules

(1) These rules apply on and after the effective date to carry out the provisions of ORS 656.245, 656.248, 656.252, 656.254, 656.260, 656.268, 656.325, 656.327, and 656.794, and govern all MCOs and insurers contracting with an MCO.

(2) Applicable to this chapter, the director may, unless otherwise obligated by statute, waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0005 Definitions

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 and OAR 436-010-0005 are hereby incorporated by reference and made a part of these rules.

(1) "Group of medical service providers" means individuals duly licensed to practice one or more of the healing arts who join together to provide managed medical services through a managed care organization, whether or not such providers have an ownership interest in the managed care organization.

(2) "GSA" means a geographic service area.

(3) "Health care provider" means an entity or group of entities, organized to provide health care services or organized to provide administrative support services to entities providing health care services. An entity solely organized to become an MCO under these rules is not, in and of itself, a health care provider.

(4) "Managed care organization" or "MCO" means an organization formed to provide medical services and certified under these rules.

(5) "Non-qualifying employer" means either:

(a) An insurer as defined under ORS 656.005(14), with respect to managed care services to be provided to any subject worker; or,

(b) An employer as defined under ORS 656.005(13), other than a health care provider, with respect to managed care services to such employer's employees.

(6) "Primary care physician" means a physician qualified to be an attending physician according to ORS 656.005(12)(b)(A) and who is a general practitioner, family practitioner, or internal medicine practitioner.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260 (ch. 423, OL 2007)
Hist: Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0006 Administration of Rules

Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and the rules adopted pursuant thereto, are considered orders of the director.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0007 Entities Allowed to Manage Care

Only an MCO may provide managed care services as described in ORS 656.260(4)(d), 656.260(20)(a), and under these rules, except as allowed under 436-015-0009. An insurer or someone acting on behalf of an insurer may not manage the care of non-MCO enrolled workers by limiting choice of medical providers, except as allowed under ORS chapter 656, or by requiring medical providers to abide by specific treatment standards, treatment guidelines, and treatment protocols.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0008 Administrative Review

(1) Any party may request that the director provide voluntary mediation after a request for administrative review or hearing is filed. The request must be in writing. When a dispute is resolved by agreement of the parties to the director's satisfaction, any agreement shall be reduced to writing and approved by the director. If the dispute does not resolve through mediation, administrative review shall continue.

(2) Administrative review before the director: The process for administrative review of such matters shall be as follows:

(a) Any party that disagrees with an action taken by an MCO pursuant to these rules must first use the MCO's dispute resolution process. If the party does not appeal the MCO's decision, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision.

(b) The aggrieved party shall file a written request for administrative review with the administrator of the Workers' Compensation Division within 60 days of the date the MCO issues a final decision under the MCO's dispute resolution process. If a party has been denied access to an MCO dispute resolution process because the complaint or dispute was not included in the MCO's dispute resolution process or because the MCO's dispute resolution process was not completed for reasons beyond a party's control, the party may request administrative review within 60 days of the failure of the MCO to issue a decision. The request must specify the grounds upon which the action is contested.

(c) The director shall create a documentary record sufficient for judicial review. The director may require and allow the parties to submit such input and information appropriate to complete the review.

(d) The director shall review the relevant information and issue an order. The order shall specify that it will become final and not subject to further review unless a written request for hearing is filed with the administrator within 30 days of the mailing date of the order.

(3) If the director determines an evaluation by a physician is indicated to resolve the dispute, the director, in accordance with OAR 436-010-0330, may appoint an appropriate medical service provider or panel of providers to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. The worker may refuse an invasive test without sanction.

(a) A single physician selected to conduct an evaluation must be a practitioner of the same healing art and specialty, if practicable, as the medical service provider whose treatment or service is being reviewed.

(b) When a panel of physicians is selected, at least one panel member must be a practitioner of the same healing art and specialty, if practicable, as the medical service provider whose treatment or service is being reviewed.

(c) When an examination of the worker is required, the director will notify the appropriate parties of the date, time, and location of the examination. No party may directly contact the physician or panel except as it relates to the examination date, time, location, and attendance. If the parties wish that the physician or panel address special questions, the parties must submit these questions to the director for screening. The director will determine the appropriateness of the questions. Matters not related to the issues before the director are inappropriate for medical evaluation, and the director will not submit questions regarding such matters to the evaluating physician(s). The evaluation may include:

(A) A review of all medical records and diagnostic tests submitted,

(B) An examination of the worker, and

(C) Any necessary and reasonable medical tests.

(4) Hearings before an administrative law judge: Any party who disagrees with an order under these rules may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order. OAR 436-001 applies to the hearing. In the review of orders issued pursuant to ORS 656.260(14) and (16), no new medical evidence or issues shall be admitted at hearing. In these reviews, administrative orders may be modified at hearing only if the administrative order is not supported by substantial evidence in the record or reflects an error of law. The dispute may be remanded to the MCO for further evidence taking, correction, or other necessary action if the administrative law judge or director determines the record has been improperly, incompletely, or otherwise insufficiently developed.

(5) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of civil penalty issued by the director pursuant to ORS 656.745, or to a civil penalty or cease and desist order issued under ORS 656.260(20), may request a hearing by the Hearings Division of the Workers' Compensation Board as follows:

(a) The party shall file a written request for a hearing with the administrator of the Workers' Compensation Division within 60 days after the mailing date of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested.

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

(c) An administrative law judge from the Hearings Division, acting on behalf of the director, shall conduct the hearing in accordance with ORS 656.740 and ORS chapter 183.

(6) Hearings on the suspension or revocation of an MCO's certification:

(a) At a hearing on a notice of intent to suspend issued pursuant to OAR 436-015-0080(2), the MCO must show cause why it should be permitted to continue to provide services under these rules.

(A) If the director determines that the acts or omissions of the MCO justify suspension of the MCO's certification, the director may issue an order suspending the MCO for a period of time up to a maximum of one year or may initiate revocation proceedings pursuant to OAR 436-015-0080(5). If the director determines that the acts or omissions of the MCO do not justify suspension, the director shall issue an order withdrawing the notice.

(B) If the MCO disagrees with the order, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(C) OAR 436-001 applies to the hearing.

(b) A revocation issued pursuant to OAR 436-015-0080(5) shall become effective within 10 days after service of such notice upon the MCO unless within such period of time the MCO corrects the grounds for revocation to the satisfaction of the director or files a written request for hearing with the administrator of the Workers' Compensation Division.

(A) If the MCO appeals, the administrator shall set a date for a hearing and shall give the MCO at least ten days notice of the time and place of the hearing. At hearing, the MCO shall show cause why it should be permitted to continue to provide services under these rules.

(B) Within thirty days after the hearing, the director shall issue an order affirming or withdrawing the revocation.

(C) If the MCO disagrees with the order, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(D) OAR 436-001 applies to the hearing.

(c) An emergency revocation issued pursuant to OAR 436-015-0080(7) is effective immediately. The MCO must file a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 183.310 thru 550; ORS 656.260, 656.325, 656.704; and 656.726(4)
Stats. Implemented: ORS 656.260, 656.325, and 656.704
Hist.: Amended 3/11/13 as Admin. Order 13-053, eff. 4/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0009 Formed/Owned/Operated

(1) The director will not certify an MCO formed, owned, or operated by a non-qualifying employer.

(2) A non-qualifying employer or any member of its staff may not:

(a) Directly participate in the formation, certification, or incorporation of the MCO;

(b) Nominate, assume a position as, or act in the role of, a director, officer, agent, or employee of the MCO; or

(c) Arrange for, lend, guarantee, or otherwise provide financing for any of the organizational costs of the MCO.

(3) A non-qualifying employer or any member of its staff, or their immediate family, may not:

(a) Arrange for, lend, guarantee, or otherwise provide financial support to the MCO (financial support does not include contracted fees for services rendered by an MCO); or

(b) Have any ownership or similar financial interest in or right to payment from the MCO.

(4) A non-qualifying employer or any member of its staff may not:

(a) Make or exercise any control over business, operational, or policy decisions of the MCO;

(b) Possess or control the ownership of voting securities of the MCO; the director will presume possession or control exists if any person, directly or indirectly, holds the power to vote or holds proxies of any other person representing ten percent or more of the voting securities of the MCO;

(c) Provide MCO services other than as allowed by section (6) of this rule;

(d) Enter into any contract with the MCO that limits the ability of the MCO to accept business from any other source; or

(e) Direct or interfere with the MCO's delivery of medical and health care services.

(5) For purposes of this rule, "staff" is any individual who is a regular employee of a non-qualified employer or of any parent or subsidiary entity of a non-qualified employer.

(6) Notwithstanding sections (2), (3), and (4) of this rule, an MCO may contract with an insurer to provide certain managed care services. However, such insurer-provided services must be in accordance with protocols and standards established by the certified MCO plan. For purposes of this rule, the insurer may not provide or participate in provision of managed care services related to dispute resolution, service utilization review, or physician peer review.

(7) An MCO may not contract exclusively with a single insurer. However, an MCO has up to one year from the effective date of its first contract to obtain contracts with more than one insurer. If the MCO has not obtained additional contracts within this time period, the MCO must provide the director with a report documenting the MCO's efforts to obtain additional contracts.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0010 Notice of Intent to Form

Any health care provider or group of medical service providers initiating an MCO under ORS 656.260, must submit a "Notice of Intent to Form" to the director, by certified mail, in a format prescribed by the director. (Form 440-2737 may be used for this purpose). The notice must include the following:

(1) Identity of the person or persons who participate in discussions intended to result in the formation of an MCO. If the person is a member of a closely held corporation, the notice should include the identity of the shareholders;

(2) The name, address, and telephone number of a contact person; and

(3) A summary of the information that will be shared in discussions preceding the application for MCO certification.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0030 Applying for Certification

(1) An applicant for MCO certification must submit to the director the following:

(a) One copy of the application;

(b) A non-refundable fee of $1,500 which will be deposited in the Consumer and Business Services Fund;

(c) Affidavits of each person identified in section (2) of this rule, certifying that the individuals have no interest in an insurance company in accordance with the provisions of OAR 436-015-0009;

(d) An affidavit of an authorized officer or agent of the MCO, certifying that the MCO is financially sound and able to meet all requirements necessary to ensure delivery of services in accordance with the plan, and in full satisfaction of the MCO's obligations under ORS 656.260 and OAR 436-015; and

(e) A complete organizational chart.

(2) The application must include:

(a) The name of the MCO;

(b) A proposed plan for the MCO, in which the applicant identifies the manner in which the MCO will meet the requirements of ORS 656.260 and these rules;

(c) The name(s) of the person(s) who will be director(s) of the MCO;

(d) The name of the person who will be the president of the MCO;

(e) The title and name of the person who will be the day-to-day administrator of the MCO; and

(f) The title and name of the person who will be the administrator of the financial affairs of the MCO.

(3) The plan must identify the initial GSA(s) in which the MCO intends to operate. (For details regarding GSAs, see http://wcd.oregon.gov/Bulletins/bul_248.pdf).

(4) The plan must provide a description of the times, places, and manner of providing services adequate to ensure that workers governed by the MCO will be able to:

(a) Access an MCO panel with a minimum of one attending physician within the MCO for every 1,000 workers covered by the plan;

(b) Receive initial treatment by the worker's choice of an attending physician or authorized nurse practitioner within 24 hours of the MCO's knowledge of the need or a request for treatment;

(c) Receive initial treatment by the worker's choice of an attending physician or authorized nurse practitioner in the MCO within 5 working days, after treatment by a physician outside the MCO;

(d) Receive information on a 24-hour basis regarding medical services available within the MCO which must include the worker's right to receive emergency or urgent care, and the hours of regular MCO operation if assistance is needed to select an attending physician or answer other questions;

(e) Receive necessary treatment from any category of medical service provider as defined in subsection (7)(a) of this rule and have a choice of at least three medical service providers within each category. The worker also must be able to choose from at least three physical therapists and three psychologists. For categories in which the MCO has fewer than three providers, the MCO must allow workers to seek treatment outside the MCO from providers in those categories, consistent with the MCO's treatment and utilization standards;

(f) Access medical providers, including attending physicians, within a reasonable distance from the worker's place of employment, considering the normal patterns of travel. For purposes of this rule, 30 miles (one way) in urban areas and 60 miles (one way) in rural areas will be considered a reasonable distance;

(g) Receive treatment by a non-MCO medical service provider when the enrolled worker resides outside the MCO's geographical service area. Such a worker may only select non-MCO providers if they practice closer to the worker's residence than an MCO provider of the same category, and if they agree to the MCO's terms and conditions;

(h) Receive services that meet quality, continuity, and other treatment standards which will provide all medical and health care services in a manner that is timely, effective, and convenient for the worker;

(i) Receive specialized medical services the MCO is not otherwise able to provide; and

(j) Receive treatment that is consistent with MCO treatment standards and protocols.

(5) The plan must provide a procedure that allows workers to receive compensable medical treatment from a primary care physician, chiropractic physician, or authorized nurse practitioner who is not a member of the MCO and has received authorization under OAR 436-015-0070.

(6) The plan must include:

(a) A copy of the standard provider agreement that is used by the MCO when a provider is credentialed as a panel provider. If there are variations from the standard provider agreement,

those must be identified when the plan is submitted for director approval.

(b) A list of the names, addresses, and specialties of the individuals who will provide services under the managed care plan. This list must indicate which medical service providers will act as attending physicians in each GSA.

(7) The plan must provide:

(a) An adequate number of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractic physician, dentist, naturopathic physician, optometric physician, osteopathic physician, medical physician, and podiatric physician, as listed in ORS 676.110. The plan must meet this section's requirements unless the MCO establishes that there is not an adequate number of providers in a given category able or willing to become members of the MCO.

(b) A process that allows workers to select a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010. If the MCO has fewer than three authorized nurse practitioners from which workers can choose within a GSA, the MCO must allow workers to seek treatment outside the MCO from authorized nurse practitioners, consistent with the MCO's treatment and utilization standards and ORS 656.245(2)(b)(D). Such authorized nurse practitioners are not themselves bound by the MCO's treatment and utilization standards; however, workers are subject to those standards.

(c) A program that specifies the criteria for selection and de-selection of physicians and the process for peer review. The processes for terminating a physician and peer review must provide adequate notice and hearing rights for any physician.

(8) The plan must provide adequate methods for monitoring and reviewing contract matters between providers and the MCO to ensure appropriate treatment and to prevent inappropriate or excessive treatment including:

(a) A program of peer review and utilization review to prevent inappropriate or excessive treatment including the following:

(A) A pre-admission review program of elective admissions to the hospital and of elective surgeries;

(B) Individual case management programs, which identify ways to provide appropriate care at a lower cost for cases that are likely to prove very costly;

(C) Physician profile analysis which may include such information as each physician's total charges, number and costs of related services provided, time loss of claimant, and total number of visits in relation to care provided by other physicians to patients with the same diagnosis. A physician's profile must not be released to anyone outside the MCO without the physician's specific written consent, except that the physician's profile must be released to the director without the necessity of obtaining such consent;

(D) Concurrent review programs, that periodically review the worker's care after treatment has begun, to determine if continued care is medically necessary;

(E) Retrospective review programs, that examine the worker's care after treatment has ended, to determine if the treatment rendered was excessive or inappropriate;

(F) Second surgical opinion programs that allow workers to obtain the opinion of a second physician when elective surgery is recommended.

(b) A quality assurance program that includes:

(A) A system for monitoring and resolving problems and complaints, including problems and complaints of workers and medical service providers;

(B) Physician peer review, which must be conducted by a group designated by the MCO or the director, and which must include members of the same healing art in which the physician practices;

(C) A standardized medical record keeping system designed to facilitate quality assurance.

(c) A program that meets the requirements of ORS 656.260(4) for monitoring and reviewing other contract matters not covered under peer review, service utilization review, dispute resolution, and quality assurance.

(9) The plan must include:

(a) A procedure for internal dispute resolution to resolve complaints by enrolled workers, medical providers, and insurers in accordance with OAR 436-015-0110. The internal dispute resolution procedure must include a provision allowing the waiver of the time period to appeal a decision to the MCO upon a showing of good cause; and

(b) A description of how the MCO will ensure the worker continues to receive appropriate care in a timely, effective, and convenient manner throughout the dispute resolution process.

(10) The plan must include a summary of the process the MCO uses to develop and review treatment standards, protocols, and guidelines. This summary must include:

(a) A description of the medical expertise or specialties of the clinicians involved;

(b) A description regarding what the protocols and guidelines are based on;

(c) The criteria the MCO uses in selecting the conditions for which the MCO implements treatment protocols and guidelines;

(d) A description of the criteria the MCO uses to determine when it needs to review or revise its treatment standards, protocols, and guidelines;

(e) How the MCO makes the standards, protocols, and guidelines available to its panel providers and how it notifies them of any changes; and

(f) A description of a process that provides sufficient flexibility to allow treatment outside the standards, protocols, and guidelines if such treatment is supported by persuasive professional medical judgment and reasoning.

(11) The plan must provide other programs that meet the requirements of ORS 656.260(4), including:

(a) A program involving cooperative efforts by the workers, the employer, the insurer, and the MCO to promote early return to work for enrolled workers; and

(b) A program involving cooperative efforts by the workers, the employer, and the MCO to promote workplace safety and health consultative and other services. The program must include:

(A) Identification of how the MCO will promote such services;

(B) A method by which the MCO will report to the insurer within 30 days of knowledge of occupational injuries and illnesses involving serious physical harm as defined by OAR 437-001, occupational injury and illness trends as observed by the MCO, and any observations that indicate an injury or illness was caused by a lack of diligence of the employer;

(C) A method by which the MCO's knowledge of needed loss control services will be communicated to the insurer for determining the need for services as detailed in OAR 437-001;

(D) A provision that all notifications to the insurer from the MCO will be considered as a request to the insurer for services as detailed in OAR 437-001; and

(E) A provision that the MCO will maintain complete files of all notifications for a period of three years following the date that notification was given by the MCO.

(12) The MCO must establish one place of business in Oregon where it administers the plan and keeps membership records and other records as required by OAR 436-015-0050.

(13) The plan must include a procedure for timely and accurate reporting to the director of necessary information regarding medical and health care service costs and utilization in accordance with OAR 436-015-0040 and OAR 436-009.

(14) The MCO must designate an in-state communication liaison for the department and the insurers at the MCO's established in-state location. The responsibilities of the liaison include:

(a) Coordinating and channeling all outgoing correspondence and medical bills;

(b) Unless otherwise provided by the MCO contract, providing centralized receipt and distribution of all reimbursements back to the MCO members and primary care physicians; and

(c) Serving as a member on the quality assurance committee.

(15) The plan must describe the reimbursement procedures for all services provided.

(16) The plan must include a process for developing financial incentives directed toward reducing service costs and utilization, without sacrificing quality of service.

(17) The plan must describe how the MCO will provide insurers with information that will inform workers of all choices of medical service providers. The plan must also describe how workers can access those providers. The plan must provide a procedure for regular, periodic updating of the MCO panel provider listings, with published updates being available electronically no less frequently than every 30 days.

(18) Within 45 days of receipt of all information required for certification, the director will notify the applicant if the certification is approved, the effective date of the certification, and the initial GSA of the MCO. If the certification is denied, the director will provide the applicant with the reason for the denial.

(19) The director will not certify an MCO if the plan does not meet the requirements of these rules.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260 (ch. 423, OL 2007)
Hist: Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0035 Coverage Responsibility of an MCO

(1) An MCO shall provide comprehensive medical services in accordance with its certification to all enrolled injured workers covered by the insurer/MCO contract.

(2) The director shall designate an MCO's initial GSA and approve any expansions to the MCO's service area. Injured workers shall not be governed by an MCO until the director has approved the geographical service area. GSAs shall be established by postal zip code. The MCO may only provide contract services to those GSAs approved by the director.

(3) Any expansion of an MCO's GSA must be approved by the director. The request for expansion must identify the postal zip code areas of the proposed expansion and include evidence that the MCO has an adequate provider panel in the new areas which meet the minimum requirements as set forth in OAR 436-015-0030. An MCO may be authorized by the director to expand the GSA without the minimum categories of medical service providers when the MCO establishes that there are not an adequate number of providers in a given category able or willing to become members of the MCO. For categories where the MCO has fewer than three providers, the MCO must allow workers to seek treatment outside the MCO from providers in those categories, consistent with the MCO's treatment and utilization standards. Such providers, unlike qualified primary care physicians and chiropractic physicians, cannot be required to comply with the terms and conditions regarding services performed by the MCO. However, while such providers are not themselves bound by the MCO's treatment and utilization standards, workers are subject to those standards.

(4) An MCO may contract only with an insurer as defined in OAR 436-010-0005. When an MCO contracts with an insurer to provide services, the contract shall specify those employers governed by the contract. The MCO/insurer contract must include the following terms and conditions:

(a) The contract must specify who is governed by the contract;

(b) The insured's place of employment must be within the authorized geographical service area;

(c) Insurers may contract with multiple MCOs to provide coverage for employers. All workers at any specific employer's

location shall be governed by the same MCO(s). When insurers contract with multiple MCOs each worker shall have initial choice at time of injury to select which MCO will manage their care except when the employer provides a coordinated health care insurance program as defined in OAR 436-010-0005.

(d) Workers enrolled in an MCO shall receive medical services in the manner prescribed by the terms and conditions of the contract; and

(e) To ensure continuity of care, the contract shall specify the manner in which injured workers will receive medical services on open claims including but not be limited to the following:

(A) Upon enrollment, allowing the worker to continue to treat with a non-qualified medical service provider for at least seven days after the mailing date of the notice of enrollment; and

(B) Upon termination or expiration of the MCO/insurer contract, allows the workers to continue treatment in accordance with ORS 656.245(4)(a).

(5) Notwithstanding the requirements of this rule, failure of the MCO to provide such medical services does not relieve the insurers of their responsibility to ensure benefits are provided injured workers under ORS chapter 656.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.245 and 260
Hist.: Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0040 Reporting Requirements For an MCO

(1) In order to ensure the MCO complies with the requirements of these rules, each MCO shall provide the director with a copy of the entire text of any MCO/insurer contract agreement, signed by the insurer and the MCO, within 30 days of execution of such contracts. Amendments, addendums, and cancellations, together with the entire text of the underlying contracts, shall be submitted to the director within 30 days of execution.

(2) Notwithstanding section (1), when an MCO/insurer contract agreement contains a specific expiration or termination date, the MCO must provide the director with a copy of a contract extension, signed by the insurer and MCO, no later than the contract's date of expiration or termination, or workers will no longer be subject to the contract after it expires or terminates without renewal pursuant to ORS 656.245(4)(a).

(3) Any amendment to the approved MCO plan must be submitted to the director for approval. The MCO shall not take any action based on the amendment until the amended plan is approved.

(4) Within 45 days of the end of each calendar quarter, each MCO shall provide the following information, current on the last day of the quarter, in a form and format as prescribed by the director: specify quarter being reported, MCO certification number, membership listings by category of medical service provider (in coded form), including provider names, specialty (in coded form), Tax ID number, National Provider Identifier (NPI) number, business address and phone number. (All fields are required unless specifically excepted by bulletin.) When a medical provider has multiple offices, only one office location in each geographical service area needs to be reported. In addition, the updated membership listing shall include the names and addresses of all health care providers participating in the MCO.

(5) By April 30 of each year, each MCO must provide the director with the following information for the previous calendar year:

(a) A summary of any sanctions or punitive actions taken by the MCO against its members;

(b) A summary of actions taken by the MCO's peer review committee; and

(c) An affidavit that the approved MCO plan is consistent with the MCO's business practices, and that any amendments to the plan have been approved by the director.

(6) By April 30 of each year, each MCO must report to the director denials and terminations of the authorization of primary care physicians, chiropractic physicians and nurse practitioners who are not members of the MCO to provide compensable medical treatment under ORS 656.245(5) and 656.260(4)(g)(A). The MCO's report must include the following:

(a) Provider type (primary care physician, chiropractic physician, or authorized nurse practitioner) reported by geographical service area (GSA).

(b) The number of workers affected, reported by provider type.

(c) Date of denial or termination.

(d) One or more of the following reason(s) for each denial or termination:

(A) Provider failed to meet the MCO's credentialing standards within the last two years;

(B) Provider has been previously terminated from serving as an attending physician within the last two years;

(C) Treatment is not in accordance with the MCO's service utilization process;

(D) Provider failed to comply with the MCO's terms and conditions after being granted come along privileges; or

(E) Other reasons authorized by statute or rule.

(7) An MCO must report any new board members or shareholders to the director within 14 days of such changes. These parties must submit affidavits certifying they have no interest in an insurer or other non-qualifying employer as described under OAR 436-015-0009.

(8) Nothing in this rule limits the director's ability to require information from the MCO as necessary to monitor the MCO's compliance with the requirements of these rules.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260 (ch. 423, OL 2007)
Hist: Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0050 Notice of Place of Business in State; Records MCO Must Keep in Oregon

(1) Every MCO shall give the division notice of one in-state location and mailing address where the MCO keeps records of the following:

(a) Updated membership listings of all MCO members;

(b) Records of any sanctions or punitive actions taken by the MCO against its members;

(c) Records of actions taken by the MCO's peer review committee;

(d) Records of utilization reviews performed in accordance with the requirements of utilization and treatment standards pursuant to ORS 656.260 showing cases reviewed, the issues involved, and the action taken;

(e) A profile analysis of each provider in the MCO listed by the International Classifications of Disease-9-Clinical Manifestations (ICD-9-CM) diagnosis;

(f) A record of those enrolled injured workers receiving treatment by non-panel primary care physicians or authorized nurse practitioners authorized to treat pursuant to OAR 436-015-0070; and

(g) All other records as necessary to ensure compliance with the certification requirements in accordance with OAR 436-015-0030.

(2) Records retained as required by section (1) of this rule must be maintained at the authorized in-state location for three full calendar years.

(3) If the MCO/insurer contract is canceled for any reason, all MCO records, as identified in section (1), relating to treatment provided to workers within the MCO must be forwarded to the insurer upon request. The records included in subsections (1)(b), (c), (d), and (e) of this rule are confidential in accordance with ORS 656.260(6) through (10).

(4) Individual MCO providers must maintain claimant medical records as provided by OAR 436-010-0240.

(5) Nothing in this section is intended to otherwise limit the number of locations the MCO may maintain to carry out the provisions of these rules.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0060 Commencement/Termination of Members

(1) Prospective new members of an MCO shall submit an application to the MCO. The directors, executive director, or administrator may approve the application for membership pursuant to the membership requirements of the MCO. The MCO shall verify that each new member meets all licensing, registration, and certification requirements necessary to practice in Oregon. If the MCO requires a membership fee, the fee shall be the same for every category of medical service provider. An MCO may not require membership fees or other MCO administrative fees to be paid by primary care physicians or authorized nurse practitioners who provide services under OAR 436-015-0070.

(2) Individual members may elect to terminate their participation in the MCO or be subject to cancellation by the MCO pursuant to the membership requirements of the MCO plan. Upon termination of a member, the MCO shall:

(a) Make alternate arrangements to provide continuing medical services for any affected injured workers under the plan.

(b) Replace any terminated member when necessary to maintain an adequate number of each category of medical service provider.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: Amended 6/14/04, as Admin. Order 04-059, eff. 6/29/04
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0070 Primary Care Physicians, Chiropractic Physicians, and Authorized Nurse Practitioners Who Are Not MCO Members

(1) The MCO must authorize a nurse practitioner or physician who is not a member of the MCO to provide medical services to an enrolled worker if:

(a) The nurse practitioner is an authorized nurse practitioner under ORS 656.245 and OAR 436-010-0005, the chiropractic physician has certified to the director that he or she has reviewed required materials under ORS 656.799, or the physician is a primary care physician under ORS 656.260(4)(g);

(b) The nurse practitioner or physician agrees to comply with all terms and conditions regarding services governed by the MCO. For purposes of this section, the phrase "all terms and conditions regarding services governed by the MCO" means MCO treatment standards, protocols, utilization review, peer review, dispute resolution, billing and reporting procedures, and fees for services in accordance with OAR 436-015-0090. However, the MCO's terms and conditions may not place limits on the length of services unless such limits are stated in ORS chapter 656; and

(c) The nurse practitioner or physician agrees to refer the worker to the MCO for specialized care, including physical therapy, to be furnished by another provider that the worker may require.

(2) The physician or authorized nurse practitioner who is not a member of the MCO will be deemed to have maintained the worker's medical records and established a documented history of treatment, if the physician's or nurse practitioner's medical records show treatment has been provided to the worker prior to the date of injury. Additionally, if an injured worker has selected a physician or authorized nurse practitioner through a private health plan, prior to the date of injury, that selected provider will be deemed to have maintained the worker's medical records and established a documented history of treatment prior to the date of injury.

(3) Notwithstanding section (1), for those workers receiving their medical services from a facility which maintains a single medical record on the worker, but provides treatment by multiple primary care or chiropractic physicians or authorized

nurse practitioners who are not MCO members, the requirements of sections (1) and (2) will be deemed to be met. In this situation, the worker must select one primary care or chiropractic physician or authorized nurse practitioner to treat the compensable injury.

(4) Any questions or disputes relating to the worker's selection of a physician or authorized nurse practitioner who is not an MCO member must be resolved pursuant to OAR 436-015-0110.

(5) Any disputes relating to a worker's non-MCO primary care or chiropractic physician's, non-MCO authorized nurse practitioner's, or other non-MCO physician's compliance with MCO standards and protocols must be resolved pursuant to OAR 436-015-0110.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0075 Worker Examinations

When the MCO schedules a worker examination that includes a psychological evaluation, the appointment letter must:

(1) Inform the worker that a psychological evaluation is part of the examination, and

(2) State the reason for the psychological examination.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Adopted 2/16/12, as Admin. Order 12-052, eff. 4/1/12

436-015-0080 Suspension; Revocation

(1) Pursuant to ORS 656.260, the certification of a managed care organization issued by the director may be suspended or revoked if:

(a) The director finds a serious danger to the public health or safety;

(b) The MCO is providing services not in accordance with the terms of the certified MCO plan;

(c) There is a change in legal entity of the MCO which does not conform to the requirements of these rules;

(d) The MCO fails to comply with ORS chapter 656, OAR 436-009, 436-010, 436-015, or orders of the director.

(e) The MCO or any of its members commits any violation for which a civil penalty could be assessed under ORS 656.254 or 656.745;

(f) Any false or misleading information is submitted by the MCO or any member of the organization;

(g) The MCO continues to utilize the services of a health care practitioner whose license has been suspended or revoked by the licensing board; or

(h) The director determines that the MCO was or is formed, owned, or operated by an insurer or by an employer other than a health care provider or medical service provider as defined in these rules.

(2) The director shall provide the MCO written notice of an intent to suspend the MCO's certification.

(a) The notice shall:

(A) Describe generally the acts of the MCO and the circumstances that would be grounds for suspension;

(B) Advise the MCO of their right to participate in a show cause hearing and the date, time, and place of the hearing.

(b) The notice shall be served upon the MCO's designated in-state communication liaison and to the registered agent or other officer of the corporation upon whom legal process may be served at least 30 days prior to the scheduled date of the hearing.

(3) The show cause hearing on the suspension shall be conducted as provided in OAR 436-015-0008(6).

(4) An order of suspension shall suspend the MCO's authority to enter into new contracts with insurers for a specified period of time up to a maximum of one year. During the suspension, the MCO may continue to provide services in accordance with the contracts in effect at the time of the suspension.

(a) A suspension may be set aside prior to the end of the suspension period if the director is satisfied of the MCO's current compliance, ability, and commitment to comply with ORS chapter 656, OAR 436-009, 436-010, 436-015, orders of the director, and the certified MCO plan.

(b) Prior to the end of the suspension period the division shall determine if the MCO is in compliance with ORS chapter 656, OAR 436-009, 436-010, 436-015, orders of the director, and the certified MCO plan. If the MCO is in compliance the suspension will terminate on its designated date. If the MCO is not in compliance the suspension may be extended beyond one year without further hearing or revocation proceedings may be initiated.

(5) The process for revocation of a MCO shall be as follows:

(a) The director shall provide the MCO with notice of an order of revocation. The order shall:

(A) Describe generally the acts of the MCO and the circumstances that are grounds for revocation; and

(B) Advise the MCO that the revocation shall become effective within 10 days after service of such notice upon the MCO unless within such period of time the MCO corrects the grounds for the revocation to the satisfaction of the director or files an appeal as provided in OAR 436-015-0008(6).

(b) The order shall be served upon the MCO's designated in-state communication liaison and to the registered agent or other officer of the corporation upon whom legal process may be served.

(c) A show cause hearing on the revocation shall be conducted as provided in OAR 436-015-0008(6).

(d) If revocation is affirmed, the revocation is effective 10 days after service of the order upon the MCO unless the MCO appeals.

(6) After revocation of an MCO's authority to provide services under these rules has been in effect for three years or longer, it may petition the director to restore its authority by making application as provided in these rules.

(7) Notwithstanding section (5) of this rule, in any case where the director finds a serious danger to the public health or safety and sets forth specific reasons for such findings, the director may immediately revoke the certification of an MCO without providing the MCO a show-cause hearing. Such order shall be final, unless the MCO requests a hearing. The process for review shall be as provided in OAR 436-015-0008(6).

(8) Insurer contractual obligations to allow a managed care organization to provide medical services for injured workers are null and void upon revocation of the MCO certification by the director.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 3/11/13 as Admin. Order 13-053, eff. 4/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0090 Charges and Fees

(1) Billings for medical services under an MCO shall be submitted in the form and format as prescribed in OAR 436-009. The payment of medical services may be less than, but shall not exceed, the maximum amounts allowed pursuant to OAR 436-009.

(2) Notwithstanding section (1) of this rule, fees paid for medical services provided by primary care physicians and chiropractic physicians who qualify under ORS 656.260(4)(g) or authorized nurse practitioners who qualify under ORS 656.245 (5) shall not be less than fees paid to MCO providers for similar medical services. Fees paid to medical providers who are not under contract with the MCO, shall be subject to the provisions of OAR 436-009.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.245 and 260
Hist: Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0095 Insurer's Rights and Duties

Insurers shall also comply with OAR 436-010 and 436-009 when carrying out their duties under these rules.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0100 Monitoring/Auditing

(1) The division shall monitor and conduct periodic audits of an MCO as necessary to ensure the compliance with the MCO certification and performance requirements.

(2) All records of an MCO and their individual members shall be disclosed upon request of the director. These records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided for the codes.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: Amended 12/16/98, as Admin. Order 98-061, eff. 1/1/99
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0110 Dispute Resolution/Complaints of Rule Violation

(1) Disputes which arise between any party and an MCO must first be processed through the dispute resolution process of the MCO.

(2) The MCO must promptly provide a written summary of the MCO's dispute resolution process to anyone who requests it, or to any party or their representative disputing any action of the MCO or affected by a dispute. The written summary must include at least the following:

(a) The title, address, and telephone number of the contact person at the MCO who is responsible for the dispute resolution process;

(b) The types of issues the MCO will consider in its dispute resolution process;

(c) A description of the procedures and time frames for submission, processing, and decision at each level of the dispute resolution process including the right of an aggrieved party to request administrative review by the director if the party disagrees with the final decision of the MCO; and

(d) A statement that absent a showing of good cause, failure to timely appeal to the MCO shall preclude appeal to the director.

(3) The MCO must notify the worker and the worker's attorney when the MCO:

(a) Receives any complaint or dispute under this rule; or

(b) Issues any decision under this rule.

(4) Whenever an MCO denies a service, or a party otherwise disputes a decision of the MCO, the MCO must send written notice of its decision to all parties that can appeal the decision. If the MCO provides a dispute resolution process for the issue, the notice must include the following paragraph, in bold text:

NOTICE TO THE WORKER AND ALL OTHER PARTIES: If you want to appeal this decision, you must notify us in writing within 30 days of the mailing date of this notice. Send a written request for review to: {MCO name and address}. If you have questions, contact {MCO contact person and phone number}. If you do not notify us in writing within 30 days, you will lose all rights to appeal the decision. If you appeal timely, we will review the disputed decision and notify you of our decision within 60 days of your request. Thereafter, if you continue to disagree with our decision, you may appeal to the director of the Department of Consumer and Business Services (DCBS) for further review. If you fail to seek dispute resolution through us, you will lose your right to appeal to the director of DCBS.

(5) If an MCO receives a complaint or dispute that is not included in the MCO dispute resolution process, the MCO must, within seven days from the date of receiving the complaint, notify the parties in writing of their right to request review by the director under OAR 436-015-0008. The notice must include the following paragraph, in bold text:

NOTICE TO THE WORKER AND ALL OTHER PARTIES: The issue you have raised is not a matter that we handle. To pursue this issue, you must request administrative review of the issue by the director of the Department of Consumer and Business Services (DCBS). Send written requests for review to: DCBS, Workers'

Compensation Division, Medical Resolution Team, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 60 days of the mailing date of this notice, you will lose all rights to appeal the decision. For assistance, you may call the Workers Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant.

(6) The time frame for resolution of the dispute by the MCO may not exceed 60 days from the date the MCO receives the dispute to the date it issues its final decision. After the MCO resolves a dispute under ORS 656.260(14), the MCO must notify all parties to the dispute in writing, including the worker's attorney where written notification has been provided by the attorney with an explanation of the reasons for the decision. This notice must inform the parties of the next step in the process, including the right of an aggrieved party to request administrative review by the director under OAR 436-015-0008. The notice must include the following paragraph, in bold text:

NOTICE TO THE WORKER AND ALL OTHER PARTIES: If you want to appeal this decision, you must notify the director of the Department of Consumer and Business Services (DCBS) in writing within 60 days of the mailing date of this notice. Send written requests for review to: Department of Consumer and Business Services, Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 60 days, you will lose all rights to appeal the decision. For assistance, you may call the Workers Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant.

(7) If the MCO fails to issue a decision within 60 days, the MCO's initial decision is automatically deemed affirmed. The parties may immediately proceed as though the MCO had issued an order affirming the MCO decision. The MCO must notify the parties of the next step in the process, including the right of an aggrieved party to request administrative review by the director under OAR 436-015-0008 including the appeal rights provided in (6) above.

(8) The director may assist in resolution of a dispute before the MCO. The director may issue an order to further the dispute resolution process. Any of the parties also may request in writing that the director assist in resolution if the dispute cannot be resolved by the MCO.

(9) Complaints pertaining to violations of these rules must be directed to the division.

(10) The division may investigate the alleged rule violation. The investigation may include, but will not be limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the complaint, or consultation with an appropriate committee of the medical provider's peers, chosen in the same manner as provided in OAR 436-010-0330.

(11) If the division determines upon completion of the investigation that there has been a rule violation, the division may issue penalties pursuant to ORS 656.745 and OAR 436-015-0120.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 3/11/13 as Admin. Order 13-053, eff. 4/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0120 Sanctions and Civil Penalties

(1) If the director finds any violation of OAR 436-015, or if the MCO fails to meet any of the requirements of the certified plan, the director may impose one or more of the following sanctions against any MCO:

(a) Reprimand by the director;

(b) Civil penalty as provided under ORS 656.745(2) and (3). All penalties collected under this section shall be paid into the Department of Consumer and Business Services Fund. In determining the amount of penalty to be assessed, the director shall consider:

(A) The degree of harm inflicted on the worker, insurer, or medical provider;

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violation.

(c) Suspension or revocation of the MCO's certification pursuant to OAR 436-015-0080.

(2) If the director determines that an insurer has entered into a contract with an MCO which violates OAR 436-015 or the MCO's certified plan, the insurer shall be subject to civil penalties as provided in ORS 656.745.

(3) If an insurer or someone who is not a certified MCO acting on the insurer's behalf engages in managed care activities prohibited under these rules, the director may impose a sanction or civil penalty.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: Amended 12/15/08, as Admin. Order 08-064, eff. 1/1/09
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 030

CLAIM CLOSURE AND RECONSIDERATION

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436-030-0001 Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.726(4) and ORS 656.268.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist.: Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0002 Purpose of Rules

The purpose of these rules is to provide standards, conditions, procedures, and reporting requirements for:

(1) Requests for closure by the worker;

(2) Claim closure under ORS 656.268(1);

(3) Determining medically stationary status;

(4) Determining temporary disability benefits;

(5) Awards of permanent partial disability;

(6) Determining permanent total disability awards;

(7) Review for reduction of permanent total disability awards;

(8) Review of prior permanent partial disability awards consistent with OAR 436-030-0003; and

(9) Reconsideration of notices of closure.

Stat. Auth.: ORS 656.268, 656.726
Stats. Implemented: ORS 656.206, 656.210, 656.212, 656.262, 656.268, 656.273, 656.325
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0003 Applicability of Rules

(1) Except as provided in section (3) of this rule, these rules apply to all accepted claims for workers' compensation benefits and all claims closed on or after the effective date of these rules.

(2) All orders the division issues to carry out the statute and these rules are considered an order of the director.

(3) These rules carry out ORS 656.005, 656.214, 656.262, 656.268, 656.273, 656.278, and 656.325.

(a) For claims in which the worker became medically stationary before July 2, 1990, OAR 436-030-0020, 436-030-0030, and 436-030-0050 as adopted by WCD Administrative Order 13-1987 effective January 1, 1988 will apply.

(b) OAR 436-030-0055(3)(b), (3)(d), and (4)(a) apply to all claims with dates of injury on or after January 1, 2002.

Stat. Auth.: ORS 656.268, 656.726
Stats. Implemented: ORS 656.206, 656.210, 656.212, 656.262, 656.268, 656.273, 656.325, 656.726
Hist.: Amended 2/12/15 as WCD Admin. Order 15-057, eff. 3/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0005 Definitions

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

(1) "Authorized Nurse Practitioner" means a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010.

(2) "Day" means calendar day unless otherwise specified (e.g., "working day").

(3) "Direct medical sequela" means a condition that is clearly established medically and originates or stems from an accepted condition. For example: The accepted condition is low back strain with herniated disc at L4-5. The worker develops permanent weakness in the leg and foot due to the accepted condition. The weakness is considered a "direct medical sequela."

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

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

(6) "Instant Fatality" means a compensable claim for death benefits where the worker dies within 24 hours of the injury.

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

(8) "Mailed or Mailing Date," for the purposes of determining timeliness under these rules, means the date a document is postmarked. Requests submitted by electronic transmission (by facsimile or "fax") will be considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped or punched in by the Workers' Compensation Division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

(9) "Notice of Closure" means a notice to the worker, estate, or beneficiary issued by the insurer to:

(a) Close an accepted disabling claim, including fatal claims;

(b) Correct, rescind, or rescind and reissue a Notice of Closure previously issued; or

(c) Reduce permanent total disability to permanent partial disability.

(10) "Reconsideration" means review by the director of an insurer's Notice of Closure.

(11) "Statutory closure date" means the date the claim satisfies the criteria for closure under ORS 656.268(1)(b) and (c).

(12) "Statutory appeal period" means the time frame for appealing a Notice of Closure or Order on Reconsideration.

(13) "Work disability," for purposes of determining permanent disability, means the separate factoring of impairment as modified by age, education, and adaptability to perform the job at which the worker was injured.

(14) "Worksheet" means a summary of facts used to derive the awards stated in the Notice of Closure.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.005, 656.268 (2015 Enrolled SB 371), 656.726
Hist: Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0007 Administrative Review

(1) Notices of Closure issued by insurers are appealed to the director and processed in accordance with the reconsideration procedures described in OAR 436-030-0115 through OAR 436-030-0185, except Notices of Closure under section (3)(b) of this rule, when:

(a) The worker was determined medically stationary after July 1, 1990; or

(b) The claim qualifies for closure under ORS 656.268(1)(b) or (c).

(2) The director may abate, withdraw, or amend the Order on Reconsideration during the 30-day appeal period for the Order on Reconsideration.

(3) The following matters are brought before the Hearings Division of the Workers' Compensation Board:

(a) Orders on Reconsideration issued under these rules.

(b) Notices of Closure that rescind permanent total disability under ORS 656.206.

(c) Any other action taken under these rules where a worker's right to compensation or the amount thereof is directly an issue under ORS chapter 656.

(4) Contested Case Hearings of Sanctions and Civil Penalties: Under ORS 656.740, any party aggrieved by a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254, 656.735, 656.745 or 656.750 may request a hearing by the Hearings Division as follows:

(a) The party must send the request for hearing in writing to the director within 60 days after the mailing date of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The Workers' Compensation Division will forward the request and other pertinent information to the Hearings Division.

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

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

(a) The party must send the request in writing to the director within 90 days of the disputed action and must specify the grounds upon which the action is disputed.

(b) The director may require and allow such evidence as is deemed appropriate to complete the review.

(c) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.268, 656.726
Stats. Implemented: ORS 656.268, 656.726, 656.740
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0015 Insurer Responsibility

(1) When an insurer issues a Notice of Closure (Form 1644, 1644c, 1644r), the insurer is responsible for:

(a) Providing the director, the parties, and the worker's attorney if the worker is represented, a copy of the Notice of Closure, a copy of the worksheet (Form 2807) upon which the Notice is based, a completed "Insurer Notice of Closure Summary" (Form 1503) and an Updated Notice of Acceptance at Closure that specifies which conditions are compensable, as prescribed in OAR 436-030-0020;

(b) Maintaining a copy of the worksheet and records upon which the Notice of Closure is based in its claim file for audit purposes under OAR 436-050; and

(c) Issuing the Updated Notice of Acceptance at Closure on the same date as the Notice of Closure.

(A) The Updated Notice of Acceptance at Closure must contain the following title, information, and language:

(i) Title: "Updated Notice of Acceptance at Closure";

(ii) Information: A list of all compensable conditions, even if a condition was denied, ordered accepted by litigation, and is under appeal. Any conditions under appeal and those which were the basis for this claim opening must be specifically identified;

(iii) Language, in bold print:

"Notice to Worker: This notice restates and includes all prior acceptances. The conditions that were the basis of this claim opening were the only conditions considered at the time of claim closure. The insurer or self-insured employer is not required to pay any disability compensation for any condition specifically identified as under appeal, unless and until the condition is found to be compensable after all litigation is complete. Appeal of any denied conditions or objections to this notice will not delay claim closure. Any condition found compensable after the Notice of Closure is issued will require the insurer to reopen the claim for processing of that condition. If you believe a condition has been incorrectly omitted from this notice, or this notice is otherwise deficient, you must communicate the specific objection to the insurer in writing.";

(B) In the case of an instant fatality, the Updated Notice of Acceptance may be combined with the Notice of Closure if the following is included:

(i) Title: "Updated Notice of Acceptance and Closure";

(ii) Information: A statement that beneficiaries may be entitled to death benefits under ORS 656.204 and 656.208, and the medically stationary date.

(iii) Language, in bold print:

"Notice to Worker's Beneficiary or Estate: This notice restates any prior acceptances. The insurer is required to determine the appropriate benefits to be paid to any beneficiaries and begin those payments within 30 days of the mailing date of this notice.

If you disagree with the notice of acceptance, you may appeal the decision to the Workers' Compensation Board, (insert current address for Workers' Compensation Board) within 30 days of the mailing date.

A beneficiary who was mailed this notice may request reconsideration of the notice by the Workers' Compensation Division, Appellate Review Unit, (insert current address for Workers' Compensation Division) within 60 days of the mailing date of this notice.

Beneficiaries who were not mailed a copy of this notice may request reconsideration of this notice within one year of the date this notice was mailed to the estate of the worker.

If you have questions about this notice, you may contact the Ombudsman for Injured Workers, the Workers' Compensation Division, or consult with an attorney."

(C) If the "Initial Notice of Acceptance" is issued at the same time as the "Updated Notice of Acceptance at Closure," both titles must appear near the top of the document.

(D) When an omission or error requires a corrected Updated Notice of Acceptance at Closure, the word "CORRECTED" must appear in capital letters adjacent to the word "Updated".

(2) The insurer or self-insured employer is not required to pay any disability compensation for any condition under appeal and specifically identified as such, unless and until the condition is found to be compensable after all litigation is complete.

(3) Copies of Notices of Refusal to Close must be mailed to the director and the parties, and to the worker's attorney, if the worker is represented.

(4) In claims with a date of injury on or after January 1, 2005, where the worker has not returned to regular work and ORS 656.726(4)(f) does not apply, or in claims with a date of injury on or after January 1, 2006, when the worker has not been released to regular work and ORS 656.726(4)(f) does not apply, the insurer must consider:

(a) The worker's age at the time the notice is issued;

(b) Adaptability to return to employment;

(c) The worker's level of education; and

(d) The worker's work history, including an accurate description of the physical requirements of the worker's job held at the time of injury, for the period from five years before the date of injury to the mailing date of the notice of closure with dates or period of time spent at each position, tasks performed or level of specific vocational preparation (SVP), and physical requirements. If the insurer cannot obtain five years of work history despite all reasonable efforts, the insurer must document its efforts and provide as much work history as it can obtain.

(5) In claims where the date of injury is before January 1, 2005, the worker has not returned or been released to regular work, ORS 656.726(4)(f) does not apply, and the claim involves injury to, or disease of, unscheduled body parts, areas, or systems, the insurer must consider:

(a) The worker's age at time the notice is issued;

(b) Adaptability to return to employment:

(c) The worker's level of education; and

(d) The worker's work history, including an accurate description of the physical requirements of the worker's job held at the time of injury, for the period from five years before the date of injury to the mailing date of the notice of closure with dates or period of time spent at each position, tasks performed or level of specific vocational preparation (SVP), and physical requirements.

(6) The insurer must consider any other records or information pertinent to claim determination prior to issuing a notice of closure.

(7) The insurer must notify the worker and the worker's attorney, if the worker is represented, in writing, when the insurer receives information that the worker's claim qualifies for closure under these rules.

(a) The insurer must send the written notice within three working days from the date the insurer receives the information, unless the claim has already been closed.

(b) The notice must advise the worker of his or her impending claim closure and that any time loss disability payments will end soon.

(8) The insurer must, within 14 days of closing the claim, provide the worker's attorney the same documents relied upon for claim closure.

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

(10) When a condition is accepted after a closure and the claim has been reopened under ORS 656.262, the insurer must issue a Notice of Closure, considering only the newly accepted condition.

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

(12) When a claim is closed where a designation of paying agent order (ORS 656.307) has been issued and the responsibility issue is not final by operation of law, the insurer processing the claim at the time of closure must send copies of the closure notice to the worker, the worker's attorney if the worker is represented, the director, and all parties involved in the responsibility issue.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.268 (2015 Enrolled SB 371), 656.331, 656.726
Hist: Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15
See also:
http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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

(1) A worker may request closure from the insurer. The insurer must issue a Notice of Closure or Notice of Refusal to Close within 10 days of receipt of a written request.

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

(a) Name of the worker;

(b) Date of injury;

(c) Insurer's claim number;

(d) Mailing date of the notice;

(e) The accepted and denied conditions;

(f) Rationale for the insurer's decision; and

(g) The following language, in bold print:

"If you disagree with this Notice of Refusal to Close your claim, you must file a letter of disagreement with the Workers' Compensation Board within sixty (60) days from the date of this notice. Your letter must state that you want a hearing, note your address, and include the date of your accident if known. You must mail your letter of disagreement to the Workers' Compensation Board, [INSURER: Insert current address of Workers' Compensation Board here]. If your claim qualifies and you request it, you may receive an expedited hearing (within 30 days). Your request cannot, by law, affect your employment. If you do not file your letter of disagreement within sixty (60) days from the date of this notice, your hearing will be denied as the appeal time has passed. You may be represented by an attorney if you choose."

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

Stat. Auth.: ORS 656.268, 656.726
Stats. Implemented: ORS 656.268, 656.319, 656.726, 656.745
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0020 Requirements for Claim Closure

(1) **Issuance of a Notice of Closure.** Unless the worker is enrolled and actively engaged in training, the insurer must issue a Notice of Closure on an accepted disabling claim within 14 days when:

(a) Medical information establishes that there is sufficient information to determine the extent of permanent disability and indicates that the worker is medically stationary;

(b) The compensable injury is no longer the major contributing cause of the worker's combined or consequential condition(s), a major contributing cause denial has been issued, and there is sufficient information to determine the extent of permanent disability;

(c) The worker fails to seek medical treatment for 30 days for reasons within the worker's control and the worker has been notified of pending actions in accordance with these rules;

(d) The worker fails to attend a mandatory closing examination for reasons within the worker's control and the worker has been notified of pending actions in accordance with these rules; or

(e) A worker receiving permanent total disability benefits has materially improved and is capable of regularly performing work at a gainful and suitable occupation.

(2) **Sufficient Information.** For purposes of determining the extent of permanent disability, except as provided in section (14) of this rule for closure after training, "sufficient information" requires: a qualifying statement of no permanent disability under subsection (a) of this section or a qualifying closing report under subsection (b) of this section. Additional documentation is required under subsection (c) of this section

unless there is clear and convincing evidence that an attending physician or authorized nurse practitioner has released the worker to the job held at the time of injury or that the worker has returned to the job held at the time of injury.

(a) **Qualifying statements of no permanent disability.** A statement indicating that there is no permanent disability is sufficient if it meets all of the following requirements:

(A) **Qualified providers.** An authorized nurse practitioner or attending physician must provide or concur with the statement.

(B) **Support by the medical record.** The statement must be supported by the medical record. If the medical record reveals otherwise, a closing examination and report specified under subsection (b) of this section are required.

(C) **In initial injury claims.** In an initial injury claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment caused in any part by an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury.

(D) **In new or omitted condition claims.** In a new or omitted condition claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(E) **In aggravation claims.** In an aggravation claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(F) **In occupational disease claims.** In an occupational disease claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(b) **Qualifying closing reports.** A closing medical examination and report are required if there is a reasonable expectation of permanent disability. A closing report is sufficient if it meets all of the following requirements:

(A) **Qualified providers.** A type A attending physician or a chiropractic physician serving as the attending physician must provide or concur with the closing report.

(B) **Release to regular work.** If the worker has no permanent work restriction, the closing report must include a statement indicating that:

(i) The worker has no permanent work restriction; or

(ii) The worker is released, without restriction, to the job held at the time of injury.

(C) **In initial injury claims.** In an initial injury claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment caused in any part by an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury.

(D) **In new or omitted condition claims.** In a new or omitted condition claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(E) **In aggravation claims.** In an aggravation claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(F) **In occupational disease claims.** In an occupational disease claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(c) **Additional documentation.** Unless there is clear and convincing evidence that an attending physician or authorized nurse practitioner has released the worker to the job held at the time of injury (for dates of injury on or after January 1, 2006) or that the worker has returned to the job held at the time of injury, all of the following is required:

(A) An accurate description of the physical requirements of the worker's job held at the time of injury, which has been provided by certified mail to the worker and the worker's legal representative, if any, either before closing the claim or at the time the claim is closed;

(B) The worker's wage established consistent with OAR 436-060;

(C) The worker's date of birth;

(D) Except as provided in OAR 436-030-0015(4)(d), the worker's work history for the period beginning five years before the date of injury to the mailing date of the Notice of Closure, including tasks performed or level of SVP, and physical demands; and

(E) The worker's level of formal education.

(3) When determining disability and issuing the Notice of Closure, the insurer must apply all statutes and rules consistent with their provisions, particularly as they relate to major contributing cause denials, worker's failure to seek treatment, worker's failure to attend a mandatory examination, medically stationary status, temporary disability, permanent partial and total disability, review of permanent partial and total disability.

(4) When issuing a Notice of Closure, the insurer must prepare and attach a summary worksheet, "Notice of Closure Worksheet," Form 2807, as described by bulletin of the director.

(5) The "Notice of Closure," Form 1644, is effective the date it is mailed to the worker and to the worker's attorney if the worker is represented, or to the worker's estate if the worker is deceased, regardless of the date on the Notice itself.

(6) The notice must be in the form and format prescribed by the director in these rules and include only the following:

(a) The worker's name, address, and claim identification information;

(b) The appropriate dollar value of any individual scheduled or unscheduled permanent disability based on the value per degree for injuries occurring before January 1, 2005 or, for injuries occurring on or after January 1, 2005, the appropriate dollar value of any "whole person" permanent disability, including impairment and work disability as determined appropriate under OAR 436-035;

(c) The body part(s) awarded disability, coded to the table of body part codes as prescribed by the director;

(d) The percentage of loss of the specific body part(s), including either the number of degrees that loss represents as appropriate for injuries occurring before January 1, 2005, or the percentage of the whole person the worker's loss represents as appropriate for injuries occurring on or after January 1, 2005;

(e) If there is no permanent disability award for this Notice of Closure, a statement to that effect;

(f) The duration of temporary total and temporary partial disability compensation;

(g) The date the Notice of Closure was mailed;

(h) The medically stationary date or the date the claim statutorily qualifies for closure under OAR 436-030-0035 or 436-030-0034;

(i) The date the worker's aggravation rights end;

(j) The appeal rights of the worker and any beneficiaries;

(k) A statement that the worker has the right to consult with the Ombudsman for Injured Workers;

(l) For claims with dates of injury before January 1, 2005, the rate in dollars per degree at which permanent disability, if any, will be paid based on date of injury as identified in Bulletin 111;

(m) For claims with dates of injury on or after January 1, 2005, the state's average weekly wage applicable to the worker's date of injury;

(n) The worker's return to work status;

(o) A general statement that the insurer has the authority to recover an overpayment;

(p) A statement that the worker has the right to be represented by an attorney; and

(q) A statement that the worker has the right to request a vocational eligibility evaluation under ORS 656.340.

(7) The Notice of Closure (Form 1644) must be accompanied by the following:

(a) The brochure "Understanding Claim Closure and Your Rights";

(b) A copy of summary worksheet Form 2807 containing information and findings which result in the data appearing on the Notice of Closure;

(c) An accurate description of the physical requirements of the worker's job held at the time of injury unless it is not required under section (2)(a) of this rule or it was previously provided under section (2)(b)(A) of this rule;

(d) The Updated Notice of Acceptance at Closure which clearly identifies all accepted conditions in the claim and specifies those which have been denied and are on appeal or which were the basis for this opening of the claim; and

(e) A cover letter that:

(A) Specifically explains why the claim has been closed (e.g., expiration of a period of suspension without the worker resolving the problems identified, an attending physician stating the worker is medically stationary, worker failure to treat without attending physician authorization or establishing good cause for not treating, etc.);

(B) Lists and describes enclosed documents; and

(C) Notifies the worker about the end of temporary disability benefits, if any, and the anticipated start of permanent disability benefits, if any.

(8) A copy of the Notice of Closure must be mailed to each of the following persons at the same time, with each copy clearly identifying the intended recipient:

(a) The worker;

(b) The employer;

(c) The director; and

(d) The worker's attorney, if the worker is represented.

(9) If the worker is deceased at the time the Notice of Closure is issued:

(a) The worker's copy of the notice must be addressed to the estate of the worker and mailed to the worker's last known address.

(b) Copies of the notice may be mailed to any known or potential beneficiaries to the worker's estate. If a copy of the notice is mailed to a beneficiary, it must be mailed by both regular mail and certified mail return receipt requested.

(10) The worker's copy of the Notice of Closure must be mailed by both regular mail and certified mail return receipt requested.

(11) An insurer may use electronically produced Notice of Closure forms if consistent with the form and format prescribed by the director.

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

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

(b) To recover overpayments for temporary disability; and

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

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

(14) Under ORS 656.268(10), if, after claim closure, the worker becomes enrolled and actively engaged in an approved training program under OAR 436-120, the insurer must again close the claim consistent with the following:

(a) The claim must be closed when the worker ceases to be enrolled and actively engaged in the training and:

(A) The worker is medically stationary;

(B) The worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions; or

(C) The claim otherwise qualifies for closure under OAR 436-030-0034.

(b) If the worker is medically stationary, there must be a current (within three months before closure) determination of medically stationary status.

(c) For claims with dates of injury on or after January 1, 2005, permanent disability must be redetermined for work disability only. For claims with dates of injury before January 1, 2005, permanent disability must be redetermined for unscheduled disability only.

(d) Except for claims closed under ORS 656.268(1)(c), the insurer must have sufficient information to redetermine work disability or unscheduled disability. The requirements in section (2) of this rule regarding sufficient information apply only as necessary for the redetermination, as follows:

(A) For claims with dates of injury on or after January 1, 2005, the insurer must have sufficient information to determine work disability under OAR 436-035-0012. An evaluation of the adaptability factor of work disability under OAR 436-035-0012(7) through (13) must be based on a current (within three months before closure) medical determination of the worker's residual functional capacity.

(B) For claims with dates of injury before January 1, 2005, the insurer must have sufficient information to determine unscheduled disability under OAR 436-035-0008(2). An evaluation of unscheduled disability must be based on a current (within three months before closure) medical determination.

(15) When, after a claim is closed, the insurer changes or is ordered to change the worker's weekly wage upon which

calculation of the work disability portion of a permanent disability award may be based, the insurer must notify the parties and the division of the change and the effect of the change on any permanent disability award. For purposes of this rule, the insurer must complete Form 1502 consistent with the instructions of the director and distribute it within 14 days of the change.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.210, 656.212, 656.214, 656.268 (2015 Enrolled SB 371), 656.726, 656.745
Hist: Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15
See also:
http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0023 Correcting and Rescinding Notices of Closure

(1) An insurer may rescind or correct its Notice of Closure prior to the expiration of the appeal period for that Notice and prior to or on the same day that the director receives a request for reconsideration of the Notice of Closure.

(2) The form, format, and completion of the Correcting and Rescinding Notices of Closure are the same as those of the Notice of Closure except that, to correct a Notice of Closure, a Form 1644c must be used and, to rescind a Notice of Closure, a Form 1644r must be used. An insurer may rescind and reissue a Notice of Closure by using a Form 1644 when such actions can be accomplished at the same time, the claim remains closed, and other provisions of these rules are met.

(3) The "Date of closure (mailing date)" on the Correcting or Rescinding Notice of Closure must be the date the correction or rescission is mailed. The mailing date of the Notice of Closure being rescinded or corrected must be identified within the body of the Correcting or Rescinding Notice of Closure.

(4) The worker's copy of the Correcting and Rescinding Notices of Closure must be mailed by both regular mail and certified mail return receipt requested, consistent with OAR 436-030-0020(8) and (10).

(5) Rescinding Notices of Closure, Form 1644r, are used to rescind the Notice of Closure and return the claim to open status. Examples of appropriate uses of Rescinding Notices of Closure include, but are not limited to:

(a) The worker was not medically stationary at the time the Notice of Closure was issued;

(b) The closure was otherwise premature;

(c) To grant PPD when the Notice of Closure being rescinded granted TTD only.

(6) The Rescinding Notice of Closure must:

(a) Advise the worker that the claim remains open and no aggravation rights end date has been established, if it is rescinding the first closure of the claim;

(b) Initiate an appeal period as provided in OAR 436-030-0145(1) during which any request for reconsideration must be received by the director;

(c) Explain the reason for the action being taken; and

(d) Be distributed and mailed to the parties consistent with these rules.

(7) When a Notice of Closure granting only time loss has been issued, if the insurer determines the worker's medically stationary status is unchanged and the worker is entitled to an award of permanent disability, the insurer must use a Notice of Closure, Form 1644, to rescind and reissue the closure. In such cases, the Notice of Closure must:

(a) Contain all required information consistent with these rules;

(b) Bear the heading "Rescind and Reissue;

(c) Explain the reason the action is being taken;

(d) Identify the permanent disability award being granted consistent with OAR 436-030 and 436-035;

(e) Establish a new appeal period as provided in OAR 436-030-0145(1);

(f) Set a new aggravation rights end date if the Notice of Closure being rescinded is the first closure of the claim; and

(g) Be distributed and mailed to the parties consistent with these rules.

(8) Correcting Notices of Closure, Form 1644c, are used to correct errors or omissions and do not change the closure status or the action taken by the Notice of Closure being corrected. Correcting Notices of Closure must not be used to grant permanent disability in claims where the Notice of Closure being corrected did not include an award of permanent disability. Examples of appropriate uses of Correcting Notices of Closure include, but are not limited to:

(a) Permanent disability award computation errors (dollars, degrees, percentages);

(b) An incorrect "mailing date";

(c) Return-to-work status errors or omissions;

(d) Incorrect or incomplete statement of temporary disability.

(9) A Correcting Notice of Closure must:

(a) Be issued when the director has instructed the insurer to do so because the Notice of Closure did not contain the information required by OAR 436-030-0020(4);

(b) Not be used to add a new condition to the claim closure, rate a new condition not considered in the Notice of Closure being corrected, or rescind a Notice of Closure;

(c) State in the body of the correcting notice only the information being corrected on the Notice of Closure and the basis for the correction;

(d) Not change the appeal period for the Notice of Closure being corrected; and

(e) Initiate a new appeal period as provided in OAR 436-030-0145(1) during which any request for reconsideration must be received, but only for those items being corrected.

Statutory authority: ORS 656.268, ORS 656.726
Statutes implemented: ORS 656.210, 656.212, 656.214, 656.268 (2015 Enrolled SB 371), 656.270, 656.726, 656.745
Hist: Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0034 Administrative Claim Closure

(1) The insurer must close a claim when the worker is not medically stationary and the worker fails to seek treatment for more than 30 days without the instruction or approval of the attending physician or authorized nurse practitioner and for reasons within the worker's control. In order to close a claim under this section, the insurer must:

(a) Wait for the 30-day lack of treatment period to expire or any additional time period recommended by the attending physician or authorized nurse practitioner before sending the worker written notification by certified mail informing the worker of the following:

(A) The worker's responsibility to seek medical treatment in a timely manner;

(B) The consequences for failing to seek treatment in a timely manner which include, but are not limited to, claim closure and possible loss or reduction of a disability award; and

(C) The claim will be closed unless the worker establishes within 14 days that:

(i) Treatment has resumed by attending an existing appointment or scheduling a new appointment; or

(ii) The reasons for not treating were outside the worker's control.

(b) Wait the 14 day period given in the notification letter to allow the worker to provide evidence that the lack of treatment was either authorized by the attending physician or authorized nurse practitioner or beyond the worker's control.

(c) Determine whether claim closure is appropriate based on the information received.

(d) Rate all permanent disability apparent in the record (e.g., irreversible findings) at the time of claim closure.

(e) Use 30 days from the last treatment provided or any additional time period authorized by the attending physician or authorized nurse practitioner as the date the claim qualifies for closure on the Notice of Closure.

(2) Regardless of whether the worker is medically stationary, the insurer must close a claim when a worker has not sought treatment for more than 30 days with a health care provider authorized under ORS 656.005 and ORS 656.245 (e.g., a worker enrolled in a managed care organization (MCO) who treats with a physician outside the MCO is not treating with an authorized health care provider). To close a claim under this section, the insurer must follow the requirements in section (1) of this rule and inform the worker that the reason for the impending closure is because the worker failed to treat with an authorized health care provider.

(3) A claim must be closed when the worker fails to attend a mandatory closing examination for reasons within the worker's control. To close a claim under this section, the insurer must:

(a) Inform the worker in writing sent by certified mail, at least 10 days prior to the mandatory closing examination of:

(A) The date, time, and place of the examination;

(B) The worker's responsibility to attend the examination;

(C) The consequences for failing to attend, which include, but are not limited to, claim closure and the possible loss or reduction of a disability award; and

(D) The worker's responsibility to provide information to the insurer regarding why the examination was not attended, if the reason was beyond the worker's control.

(b) Wait 7 days from the date of the missed exam to allow the worker to demonstrate good cause for failing to attend before closing the claim.

(c) Use the date of the failed mandatory closing examination as the date the claim qualifies for closure on the Notice of Closure.

(4) The insurer may close the claim under section (1) of this rule, regardless of whether the worker is medically stationary, when a closing exam has been scheduled between a worker and attending physician directly and the worker fails to attend the examination.

(5) A claim may be closed when the worker is not medically stationary and a major contributing cause denial has been issued on an accepted combined condition.

(a) The major contributing cause denial must inform the worker that claim closure may result from the issuance of the denial and provide all other information required by these rules.

(b) When a major contributing cause denial has been issued following the acceptance of a combined condition, the date the claim qualifies for closure is the date the insurer receives sufficient information to determine the extent of any permanent disability under OAR 436-030-0020(2) or the date of the denial, whichever is later.

(6) When two or more of the above events occur concurrently, the earliest date the claim qualifies for closure is used to close the claim.

(7) The attending physician or authorized nurse practitioner must be copied on all notification and denial letters applicable to this rule.

(8) When the director has issued a suspension order under OAR 436-060-0095 or OAR 436-060-0105, the date the claim qualifies for closure is the date of the suspension order.

Stat. Auth.: ORS 656.262, 656.268, 656.726
Stats. Implemented: ORS 656.268, 656.726
Hist.: Amended 1/29/15 as WCD Admin. Order 15-052, eff. 3/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0035 Determining Medically Stationary Status

(1) A worker is medically stationary in the following circumstances:

(a) **In initial injury claims.** In an initial injury claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted conditions, direct medical sequela of accepted conditions, and conditions directly resulting from the work injury are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(b) **In new or omitted condition claims.** In a new or omitted condition claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted new or omitted conditions and direct medical sequela of accepted new or omitted conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(c) **In aggravation claims.** In an aggravation claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted worsened conditions and direct medical sequela of accepted worsened conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(d**) In occupational disease claims.** In an occupational disease claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted occupational diseases and direct medical sequela of accepted occupational diseases are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(2) When there is a conflict in the medical opinions as to whether a worker is medically stationary, more weight is given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and clear and concise reasoning.

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

(4) When there is a conflict as to the date upon which a worker became medically stationary, the following conditions govern the determination of the medically stationary date. The date a worker is medically stationary is the earliest date that a preponderance is established under sections (1) and (2) of this rule. The date of the examination, not the date of the report, controls the medically stationary date.

(5) The insurer must request the attending physician, as defined in ORS 656.005(12)(b)(A), to concur or comment when the attending physician arranges or refers the worker for a closing examination with another physician to determine the extent of impairment or when the insurer refers a worker for an independent medical examination. A concurrence with another physician's report is an agreement in every particular, including the medically stationary impression and date, unless the physician expressly states to the contrary and explains the reasons for disagreement. Concurrence cannot be presumed in the absence of the attending physician's response.

(6) A worker is medically stationary on the date of the examination when so specified by a physician. When a specific date is not indicated, a worker is presumed medically stationary on the date of the last examination, prior to the date of the medically stationary opinion. Physician projected medically stationary dates cannot be used to establish a medically stationary date.

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

(8) If a worker dies and the attending physician has not established a medically stationary date, for purposes of claim closure, the medically stationary date is the date of death.

Stat. Auth.: ORS 656.268, ORS 656.726; Stats. Implemented: ORS 656.268
Hist.: Amended 1/29/15 as WCD Admin. Order 15-052, eff. 3/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0036 Determining Temporary Disability

(1) Temporary disability must be determined under ORS chapter 656, OAR 436-060, and this rule, less time worked. Beginning and ending dates of each authorized period of temporary total disability and temporary partial disability must be noted on the Notice of Closure, as well as the statements "Less time worked" and "Temporary disability was determined in accordance with the law."

(2) Except as provided in section (3) of this rule and ORS 656.268(10), a worker is not entitled to any award of temporary disability for any period of time in which the worker is medically stationary.

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

Stat. Auth.: ORS 656.268, 656.726
Stats. Implemented: ORS 656.005, 656.160, 656.210, 656.212, 656.236, 656.245, 656.262, 656.268, 656.726
Hist.: Amended 11/17/2011 as WCD Admin. Order 11-058, eff. 1/1/12
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0038 Permanent Partial Disability

The standards developed under ORS 656.726(4) and contained in OAR 436-035 must be applied when evaluating a worker's permanent partial disability.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.214, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist.: Amended 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0055 Determining Permanent Total Disability

(1) A worker is permanently and totally disabled if permanently incapacitated from regularly performing work in a suitable and gainful occupation. For the purpose of this rule and OAR 436-030-0065:

(a) "Incapacitated from regularly performing work" means that the worker does not have the necessary physical and mental capacity and the work skills to perform the essential functions of the job. Employment in a sheltered workshop is

not considered regular employment unless this was the worker's job at the time of injury.

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

(c) "Gainful occupation" means those types of general occupations that provide wages that:

(A) Meet the requirements in ORS 656.206(11)(a) for workers with a date of injury prior to January 1, 2006; or

(B) Meet the requirements in ORS 656.206(11)(b) for workers with a date of injury on or after January 1, 2006.

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

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

(A) The area within a 50-mile radius of the worker's place of residence at the time of:

(i) The original injury;

(ii) The worker's last gainful employment;

(iii) Insurer's determination; or

(iv) Reconsideration by the director.

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

(f) "Types of general occupations" means groups of jobs which actually exist in a normal labor market, and share similar vocational purpose, skills, duties, physical circumstances, goals, and mental aptitudes. It does not refer to any specific job or place of employment for which a job or job opening may exist in the future.

(g) "Normal labor market" means a labor market that is undistorted by such factors as local business booms and slumps or extremes of the normal cycle of economic activity, or technology trends in the long-term labor market.

(h) "Withdrawn from the workforce" means a worker who is not employed, is not willing to be employed, or although willing to be employed is not making reasonable efforts to find employment, unless such efforts would be futile. The receipt of retirement benefits does not establish a worker has withdrawn from the workforce.

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

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

(a) Prove permanent and total disability;

(b) Be willing to seek regular and gainful employment;

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

(d) Not have withdrawn from the workforce during the period for which benefits are being sought.

(4) A worker retaining some residual functional capacity and not medically permanently and totally disabled must prove:

(a) The worker has not withdrawn from the workforce for the period for which benefits are being sought;

(b) Inability to regularly perform work at a gainful and suitable occupation; and

(c) The futility of seeking work if the worker has not made reasonable work search efforts by competent written vocational testimony. Competent written vocational testimony is that which is available at the time of closure or reconsideration and comes from the opinions of persons fully certified by the State of Oregon to render vocational services.

(5) Notices of Closure and Orders on Reconsideration which grant permanent total disability must notify the worker that:

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

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

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

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

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

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Statutes implemented:ORS 656.005, ORS 656.206, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, 1999 OR Laws Chapter 313, and chapter 865, Oregon Laws 2001
Hist.: Amended 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0065 Review of Permanent Total Disability Awards

(1) The insurer must reexamine each permanent total disability claim at least once every two years or when requested to do so by the director to determine if the worker has materially improved, either medically or vocationally, and is capable of regularly performing work at a suitable and gainful occupation. The insurer must notify the worker and the worker's attorney if the worker is represented whenever the insurer intends to reexamine the worker's permanent total disability status. Workers who fail to cooperate with the reexamination may have benefits suspended under OAR 436-060-0095.

(2) A worker receiving permanent total disability benefits must submit to a vocational evaluation, if requested by the director, insurer, or self-insured employer under ORS 656.206(8).

(3) Any decision by the insurer to reduce permanent total disability must be communicated in writing to the worker, and to the worker's attorney if the worker is represented, and accompanied by documentation supporting the insurer's decision. That documentation must include: medical reports, including sufficient information necessary to determine the extent of permanent partial disability, vocational and investigation reports (including visual records, if available) that demonstrate the worker's ability to regularly perform a suitable and gainful occupation, and all other applicable evidence.

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

(5) Except for section (4) of this rule, an award of permanent total disability may be reduced only when the insurer has a preponderance of evidence that the worker has materially improved, either medically or vocationally, and is regularly performing work at a suitable and gainful occupation or is currently capable of doing so. Preexisting disability must be included in redetermination of the worker's permanent total disability status.

(6) When the insurer reduces a permanent total disability claim, the insurer must, based upon sufficient information to determine the extent of permanent partial disability, issue a Notice of Closure that reduces the permanent total disability and awards permanent partial disability, if any.

(7) Notices of Closure reducing permanent total disability are appealable to the Hearings Division.

(8) If a worker is receiving permanent total disability benefits and sustains a new compensable injury, the worker is eligible for additional benefits for the new compensable injury, except that the worker's eligibility for compensation for the new compensable injury is limited to medical benefits under ORS 656.245 and permanent partial disability benefits for impairment, as determined in the manner set forth in ORS 656.214(2).

Stat. Auth.: ORS 656.268, 656.726
Stats. Implemented: ORS 656.206, 656.214, 656.268, 656.283, 656.319, 656.325, 656.331, 656.726
Hist.: Amended 1/29/15 as WCD Admin. Order 15-052, eff. 3/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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

(1) For claims having a date of injury prior to January 1, 2005 which involve unscheduled body parts, areas, or systems as defined by OAR 436-035-0005, and all claims with dates of injury on or after January 1, 2005, an award of permanent partial disability is subject to periodic examination and adjustment under ORS 656.268 and 656.325 and in accordance with the following conditions:

(a) Requests for review and adjustment must be made in writing to the Workers' Compensation Division.

(b) The party requesting review of permanent disability must send a copy of the request to all involved parties at the time the request is made. The worker may submit any information in rebuttal.

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

(d) The basis for the request for adjustment in the permanent disability award must be asserted to be failure of the worker to make a reasonable effort to reduce the disability.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.325, ORS 656.331, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and
1999 OR Laws Chapter 313
Hist.: Amended 10/26/04 as WCD Admin. Order 04-062, eff. 1/1/05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0115 Reconsideration of Notices of Closure

(1) A worker, insurer, or beneficiary may request reconsideration of a Notice of Closure as provided in ORS 656.268.

(2) Under ORS 656.218(4), a worker's estate may request reconsideration of a Notice of Closure if the worker dies before filing a request and there are no persons entitled to receive death benefits under ORS 656.204.

(3) A request for reconsideration may be made by mailing, phoning, or delivering the request to the director within the statutory appeal period as defined in OAR 436-030-0005 and 436-030-0145(1). The reconsideration proceeding begins as described in OAR 436-030-0145(2).

(4) For the purpose of these rules, "reconsideration proceeding" means the procedure established to reconsider a Notice of Closure and does not include personal appearances by any of the parties to the claim or their representatives, unless requested by the director. All information to correct or clarify the record and any medical evidence regarding the

worker's condition as of the time of claim closure that should have been but was not submitted by the attending physician or authorized nurse practitioner at the time of claim closure and all supporting documentation must be presented during the reconsideration proceeding. When the reconsideration proceeding is postponed because the worker's condition is not medically stationary under OAR 436-030-0165(10), medical evidence submitted may address the worker's condition after claim closure as long as the evidence satisfies the conditions of OAR 436-030-0145(3).

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

(6) The worker may submit a deposition to the reconsideration record subject to ORS 656.268(6) and the following:

(a) The deposition must be limited to the testimony and cross-examination of a worker about the worker's condition at the time of claim closure.

(b) The deposition must be arranged by the worker and held during the reconsideration proceeding time frame unless a good cause reason is established. If a good cause reason is established, the time frame for holding the deposition may be extended but must not extend beyond 30 days from the date of the Order on Reconsideration. The deposition must be held at a time and place that permits the insurer or self-insured employer the opportunity to cross-examine the worker.

(c) The insurer or self-insured employer must, within 30 days of receiving a bill for the deposition, pay the fee of the court reporter, the costs for the original transcript and one copy for each party, and the cost of necessary interpreter services. An original transcript of the deposition must be sent to the department and each party must be sent a copy of the transcript.

(d) If the transcript is not completed and presented to the department prior to the deadline for issuing an Order on Reconsideration, the Order on Reconsideration may not be postponed to receive a deposition under this rule and the order will be issued based on the evidence in the record. However, the transcript may be received as evidence at a hearing for an appeal of the Order on Reconsideration.

(7) Only one reconsideration proceeding may be completed on each Notice of Closure and the director will review those issues raised by the parties and the requirements under ORS 656.268(1). Once the reconsideration proceeding is initiated, issues must be raised and further evidence submitted within the time frames allowed for processing the reconsideration request. When the director requires additional information to complete the record, the reconsideration proceeding may be postponed under ORS 656.268(6).

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.268 (2015 Enrolled SB 371)
Hist: Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0125 Reconsideration Form and Format

A request for reconsideration may be in the form and format the director provides by bulletin. A reconsideration request should include at least the following:

(1) Worker's name;

(2) Date of injury;

(3) Date of the closure being appealed;

(4) Any specific issues regarding the Notice of Closure;

(5) The name of the worker's attorney;

(6) The name of the insurer's attorney;

(7) If the request is made by a beneficiary of the worker or the worker's estate, the identity and name of the requester, the name of the requester's attorney, if any, and contact information;

(8) Any special language needs;

(9) Whether there is disagreement with the specific impairment findings used to determine permanent disability at the time of claim closure;

(10) Any information and documentation deemed necessary to correct or clarify any part of the claim record believed to be erroneous; and

(11) Any medical evidence that should have been but was not submitted at the time of the claim closure including clarification or correction of the medical record based on the examination(s) at, before, or pertaining to claim closure.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.268 (2015 Enrolled SB 371)
Hist: Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0135 Reconsideration Procedure

(1) Within 14 days from the date of the director's notice of the start of the reconsideration proceeding, the insurer must provide, in chronological order by document date, all documents pertaining to the claim including, but not limited to, the complete medical record and all official action and notices on the claim, to:

(a) The director;

(b) The worker or the worker's attorney;

(c) The beneficiary or beneficiary's attorney, if the request was made by the beneficiary; and

(d) The estate or estate's attorney, if the request was made by the worker's estate.

(2) The request for reconsideration and all other information submitted to the director by any party during the reconsideration process must be copied to all interested parties. Failure to comply with this requirement may result in the information not being included as part of the record on reconsideration.

(3) The director may issue an order rescinding a Notice of Closure if any of the following apply:

(a) The claim was not closed as prescribed by rule.

(b) In a claim closed under ORS 656.268(1)(a), the worker was not medically stationary at the time of claim closure.

(c) In a claim closed under ORS 656.268(1)(a) or 656.268(1)(b), the claim was closed without sufficient information to determine the extent of permanent disability under OAR 436-030-0020(2).

(d) In a claim closed under ORS 656.268(1)(c), the claim was not closed in strict compliance with OAR 436-030-0034.

(4) When a worker has requested and cashed a lump sum payment, under ORS 656.230, of an award granted by a Notice of Closure, the director will not consider the adequacy of that award in a reconsideration proceeding.

(5) When a new condition is accepted after a prior claim closure, and the newly accepted condition is subsequently closed, the director and the parties may mutually agree to consolidate requests for review of the closures into one reconsideration proceeding, provided the director has jurisdiction and neither of the closures have become final by operation of law.

(6) The reconsideration order may affirm, reduce, or increase the compensation awarded by the Notice of Closure.

(7) After the reconsideration order has been issued and before the end of the 30-day appeal period for the order on reconsideration, if a party discovers that additional documents were not provided by the opposing party in accordance with this rule, the Order on Reconsideration may be abated and withdrawn to give the party an opportunity to respond to the new information.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.268 (2015 Enrolled SB 371)
Hist: Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0145 Reconsideration Time Frames and Postponements

(1) When appealing a Notice of Closure for claims that are medically stationary or that statutorily qualified for closure on or after June 7, 1995, a request for reconsideration must be mailed within:

(a) Sixty (60) days of the mailing date of the Notice of Closure for a worker's request.

(b) Seven (7) days of the mailing date of the Notice of Closure for an insurer's request. An insurer's request for reconsideration is limited to the findings used to rate impairment.

(c) Sixty (60) days of the mailing date of the Notice of Closure for a beneficiary's request if the Notice of Closure was mailed to the beneficiary under ORS 656.268(5)(b).

(d) One year of the date the Notice of Closure was mailed to the estate of the worker if the Notice of Closure was not mailed to the beneficiary under ORS 656.268(5)(b).

(2) The reconsideration proceeding begins upon:

(a) The director's receipt of the worker's, estate's, or beneficiary's request for reconsideration, if the insurer has not previously requested reconsideration consistent with subsection (1)(b) of this rule; or

(b) The 61st day after the closure of the claim, if the insurer has requested reconsideration consistent with subsection (1)(b) of this rule, unless the director receives, within the appeal time frames in section (1) of this rule, a request for reconsideration or a statement by the worker, estate, beneficiary, or representative instructing the director to start the reconsideration proceeding.

(3) Fourteen days from the date of the director's notice of the start of the reconsideration proceeding, the reconsideration request and all other appropriate information submitted by the parties will become part of the record used in the reconsideration proceeding. Requests for a medical arbiter panel must be submitted within this time frame.

(a) Evidence received or issues raised subsequent to the 14-day deadline will be considered in the reconsideration proceeding to the extent practicable.

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

(c) Except as provided in sections (4), (5), and (6) of this rule, the director will either mail an Order on Reconsideration within 18 working days from the date the reconsideration proceeding begins or notify the parties that the reconsideration proceeding is postponed for not more than 60 additional days as provided under ORS 656.268(6).

(4) The director may delay the reconsideration proceeding and toll the reconsideration timeline for up to 45 days when both parties provide written notice to the director requesting the delay for settlement negotiations. The notice is only effective if the director receives it before the 18th working day after the reconsideration proceeding begins.

(a) This delay of the reconsideration proceeding expires:

(A) When the director receives a written request from either party to resume the reconsideration proceeding;

(B) When the director receives a copy of the approved settlement resolving some or all of the issues raised at the reconsideration proceeding; or

(C) On the next calendar day following the authorized delay period.

(b) The director may authorize only one delay period for each reconsideration proceeding.

(5) When the director provides notice the worker failed to attend the medical arbiter examination without good cause or failed to cooperate with the arbiter examination and suspends benefits under ORS 656.268(8), the reconsideration proceeding will be postponed for up to 60 additional days from the date the director determines and provides notice, to allow completion of the arbiter process.

(6) The reconsideration proceeding may be stayed for one of the following reasons:

(a) The parties consent to deferring the reconsideration proceeding, under ORS 656.268(8)(i)(B), when the medical arbiter examination is not medically appropriate because the worker's medical condition is not stationary; or

(b) When a claim disposition agreement (CDA) is filed, the reconsideration proceeding is stayed until the CDA is either approved or set aside.

(7) If the director fails to mail an Order on Reconsideration or a Notice of Postponement under the time frames specified in ORS 656.268, the reconsideration request is automatically deemed denied. The parties may immediately thereafter proceed as though the director had issued an Order on Reconsideration affirming the Notice of Closure.

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

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.268 (2015 Enrolled SB 371)
Hist: Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0155 Reconsideration Record

(1) The record for the reconsideration proceeding includes all documents and other material relied upon in issuing the Order on Reconsideration as well as any additional material submitted by the parties, but not considered in the reconsideration proceeding.

(a) The record is maintained in the Workers' Compensation Division's claim file and consists of all documents and material received and date stamped by the director prior to the issuance of the Order on Reconsideration, unless the document is an exact duplicate of what is in the file then the director is not required to retain the duplicate document.

(b) The insurer or self-insured employer must not send billing information and duplicate documents to the department, unless specifically requested by the director.

(c) Evidence stored by the parties on audio media and submitted as part of the reconsideration record may only be submitted in transcribed form.

(2) Except as noted in this section, the medical record submitted by the director for arbiter review will consist of all medical documents and medical material produced by the claim under reconsideration, provided the information is allowable under ORS 656.268.

(3) The director will send non-medical information, nursing notes, or physical therapy treatment notes to the arbiter if:

(a) A party requests the director to submit those specific materials;

(b) The party identifies and provides the director with specific dates of those materials requested to be submitted; and

(c) The materials otherwise meet the requirements of this rule.

(4) When any surveillance video obtained prior to closure has been submitted to a physician involved in the evaluation or treatment of the worker, it must be provided for arbiter review.

(a) Surveillance video provided for arbiter review must have been reviewed prior to claim closure by a physician involved in the evaluation or treatment of the worker.

(b) All written materials previously forwarded to a physician along with the surveillance video, such as investigator field notes, summary or narrative reports, and cover letters, must also be submitted.

(c) Surveillance video must be labeled according to the date and total time of the recording.

(5) When reconsideration is requested, the insurer is required to provide the director and the other parties with a copy of all documents contained in the record at claim closure. For cases involving a health care provider who must meet criteria other than those of an attending physician or who practices under contract with a managed care organization, the insurer must provide documentation of the health care provider's authority to act as an attending physician. Responses of the parties to the medical arbiter report will be included in the record if received prior to completion of the reconsideration proceeding.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.268
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0165 Medical Arbiter Examination Process

(1) The director will select a medical arbiter physician or a panel of physicians in accordance with ORS 656.268(8)(d).

(a) Any party that objects to a physician on the basis that the physician is not qualified under ORS 656.005(12)(b) must notify the director of the specific objection before the examination. If the director determines that the physician is not qualified to be a medical arbiter on the specific case, an examination will be scheduled with a different physician.

(b) When the worker resides outside the state of Oregon, a medical arbiter examination may be scheduled out-of-state with a physician who is licensed within that state to provide medical services in the same manner as required by ORS 656.268(8).

(c) Arbiters or panel members will not include any health care provider whose examination or treatment is the subject of the review.

(d) The insurer must pay all costs related to the completion of the medical arbiter process in this rule.

(2) If the director determines there are enough appropriate physicians available to create a list of possible arbiters and it is practicable, each party will be given the opportunity to agree on a physician and to remove one physician from the list through the process described below:

(a) The director will send the list to the parties electronically or by overnight mail.

(b) If the parties agree on a physician, every party must send a signed, written notice of that choice to the director.

(c) A party can remove a physician from the list, even when the parties have agreed on a physician to conduct the exam, by submitting a signed, written notice of that choice to the director.

(d) To be effective, the written notice of agreement on or rejection of a physician must be received by the director within three working days of the date the director sent the list.

(3) The worker's disability benefits will be suspended when the director determines the worker failed to attend or cooperate with the medical arbiter examination, unless the worker establishes a "good cause" reason for missing the examination or for not cooperating with the arbiter. The worker must call the director within 24 hours of the missed examination to provide any "good cause" reason.

(a) Notice of the examination will be considered adequate notice if the appointment letter is mailed to the last known address of the worker and to the worker's attorney, if the worker is represented.

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

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

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

(5) Upon determination that there was not a "good cause" reason for missing the examination, or that the worker failed to cooperate with the arbiter, the worker's disability benefits will be suspended and the reconsideration proceeding postponed for up to an additional 60 days.

(6) The suspension will be lifted if any of the following occur during the additional 60-day postponement period:

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

(b) The worker withdraws the request for reconsideration; or

(c) The worker attends and cooperates with a rescheduled arbiter examination.

(7) If none of the events that end the suspension under section (6) of this rule occur before the expiration of the 60-day additional postponement, the suspension of benefits will remain in effect.

(8) The medical arbiter or panel of medical arbiters must perform a record review or examine the worker as requested by the director and perform such tests as may be reasonable and necessary to establish the worker's impairment.

(a) The parties must submit to the director any issues they wish the medical arbiter or panel of medical arbiters to address within 14 days of the date of the director's notice of the start of the reconsideration proceeding. The parties must not submit issues directly to the medical arbiter or panel of medical arbiters. The medical arbiter or panel of medical arbiters will only consider issues appropriate to the reconsideration proceeding.

(b) The report of the medical arbiter or panel of medical arbiters must address all questions raised by the director.

(c) The medical arbiter will provide copies of the arbiter report to the director, the worker or the worker's attorney, and the insurer within five working days after completion of the arbiter review. The cost of providing copies of such additional reports must be reimbursed according to OAR 436-009-0060 and must be paid by the insurer.

(9) When a worker's medical condition prevents the worker from fully participating in a medical arbiter examination that must be conducted to determine findings of impairment, the director may send a letter to the parties requesting consent to defer the reconsideration proceeding. The medical condition that prevents the worker from participating in the medical arbiter examination does not need to be related to the work injury.

(a) If the parties agree to the deferral, the reconsideration proceeding will be deferred until the medical record reflects the worker's condition has stabilized sufficiently to allow for examination to obtain the impairment findings. The parties must notify the director when it is appropriate to schedule the medical arbiter examination and provide the necessary medical records when requested. Interim medical information that may be helpful to the director and the medical arbiter in assessing and describing the worker's impairment may be submitted at the time the parties notify the director that the medical arbiter examination can be scheduled. The director will determine whether the interim medical information is consistent with the provisions of ORS 656.268(6) and (8).

(b) If deferral is not appropriate, at the director's discretion either a medical arbiter examination or a medical arbiter record review may be obtained, or the director may issue an Order on Reconsideration based on the record available at claim closure and other evidence submitted in accordance with ORS 656.268(6).

(10) All costs related to record review, examinations, tests, and reports of the medical arbiter must be billed and paid under OAR 436-009-0010, 436-009-0030, 436-009-0040, and 436-009-0060.

(11) When requested by the Hearings Division, the director may schedule a medical arbiter examination for a worker who has appealed a Notice of Closure rescinding permanent total disability benefits under ORS 656.206.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.268
Hist.: Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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

(1) An insurer failing to provide information or documentation as set forth in OAR 436-030-0135, 436-030-0145, 436-030-0155 and 436-030-0165 may be assessed civil penalties under OAR 436-030-0580. Failure to comply with the requirements set forth in OAR 436-030-0135, 436-030-0145, 436-030-0155, and 436-030-0165 may also be grounds for extending the reconsideration proceeding under ORS 656.268(6).

(2) If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer will be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent disability compensation. Penalties will not be assessed if an increase in compensation results from one of the following:

(a) An order issued by the director that addresses the extent of the worker's permanent disability that is not based on the standards adopted under ORS 656.726(4)(f);

(b) New information is obtained through a medical arbiter examination, for claims with medically stationary dates or statutory closure dates on or after June 7, 1995; or

(c) Information that the insurer or self-insured employer demonstrates they could not reasonably have known at the time of claim closure.

(3) For the purpose of section (2) of this rule, a worker who receives a total sum of 64 degrees of scheduled or unscheduled disability or a combination thereof, will be found to be at least 20 percent disabled.

For example: A worker who receives 20 percent disability of a great toe (3.6 degrees) is not considered 20 percent permanently disabled because the great toe is only a portion of the whole person. A worker who is 100 percent permanently disabled is entitled to 320 degrees of disability. A worker who receives 64 degrees (20 percent of 320 degrees), whether scheduled, unscheduled or a combination thereof, will be considered the equivalent of at least 20 percent permanently disabled for the purposes of this rule.

(4) Attorney fees may only be authorized when a Request for Reconsideration is submitted by an attorney representing a worker or the attorney provides documentation of representation, and a valid signed retainer agreement has been filed with the director. The insurer must pay the attorney 10 percent out of any additional compensation awarded. "Additional compensation" includes an increase in a permanent or temporary disability award.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.268
Hist.: Amended 11/1/07 as WCD Admin. Order 07-059, eff. 1/2/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0185 Reconsideration: Settlements and Withdrawals

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

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

(b) List the body part for which any award is made and recite all disability awarded in both degrees and percent of loss as appropriate based on date of injury when permanent partial disability is part of the stipulated agreement. In the event there is any inconsistency between the stated degrees and percent of loss awarded in any stipulated agreement for claims with dates of injury prior to January 1, 2005, the stated percent of loss will control.

(2) The director will review the stipulation and issue an order approving or denying the stipulation. Stipulations approved by the director can not be appealed.

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

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

(a) Address the disapproval, or

(b) Request that the director issue an Order on Reconsideration addressing the substantive issues.

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

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

(a) A written request for an affirming reconsideration order must:

(A) Be made by certified mail;

(B) Be signed by both parties or their representatives;

(C) State that the parties waive their right to an arbiter review and that all matters subject to the mandatory reconsideration process have been resolved; and

(D) Be accompanied by a copy of the proposed stipulated agreement.

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

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

(d) This provision does not apply to Claims Disposition Agreements filed under ORS 656.236.

(7) A worker requesting a reconsideration may withdraw the request for reconsideration without agreement of the other parties only if:

(a) No additional information has been submitted by the other parties;

(b) No medical arbiter exam has occurred, and

(c) The insurer has not requested reconsideration under OAR 436-030-0145.

(8) Notwithstanding (7) above, if additional information has been submitted by the other party(ies), a medical arbiter exam has occurred or the insurer has requested reconsideration, the reconsideration request will not be dismissed unless all parties agree to the withdrawal.

(9) If the insurer has requested reconsideration, either the worker or the insurer may initiate the withdrawal request but both must agree to the withdrawal.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.268
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0575 Audits

(1) Notices of Closure issued by insurers and supporting documentation including, but not limited to, the worksheet upon which the Notice of Closure is based, will be subject to periodic audit by the director. Supporting documentation and records must be maintained in accordance with OAR 436-050.

(2) The director reserves the right to visit the worksite to determine compliance with these rules.

(3) The insurer or self-insured employer is required to provide the director, within seven days of the director's request, any data the director identifies as necessary to determine the impact of legislative changes on permanent partial disability awards.

Stat. Auth.: ORS 656.268, ORS 656.726, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.268, ORS 656.455, ORS 656.726, ORS 656.750, and 1999 OR Laws Chapter 313
Hist.: Amended 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0580 Penalties and Sanctions

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

(2) An insurer or health care provider failing to meet the requirements set forth in these rules may be assessed a civil penalty.

(3) Under OAR 436-010-0340, the director may impose sanctions for any health care provider where the insurer can provide sufficient documentation to substantiate lack of cooperation. The medical service provider will be sent a warning letter about the reporting requirements and possible penalties. Failure by the health care provider to submit the requested information within the specified period may result in civil penalties.

(4) Sufficient documentation to substantiate lack of cooperation by the health care provider includes:

(a) Copies of letters to the health care provider;

(b) Memos to the claim file of follow-up phone calls or the lack of response;

(c) Letters from the health care provider indicating a lack of cooperation; or

(d) Medical reports received by the insurer, after adequate instruction by the insurer or the director, which do not supply the requested information or which supply information that is not consistent with the Disability Rating Standards in OAR 436-035.

Stat. Auth.: ORS 656.268, 656.726
Stats. Implemented: ORS 656.268, 656.726, 656.745
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 035

DISABILITY RATING STANDARDS

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436-035-0001 Authority for Rules

These rules are promulgated under the Director's authority contained in ORS 656.726(4).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 1-14-03 as WCD Admin. Order 03-050, eff. 2-1-03
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0002 Purpose of Rules

These rules establish standards for rating permanent disability under the Workers' Compensation Act. These standards are written to reflect the criteria for rating outlined in ORS chapter 656 and assign values for disabilities that are applied consistently at all levels of the workers' compensation award and appeal process.

Stat. Auth.: ORS 656.726
Stats. Implemented.: ORS 656.005, 656.012, 656.210, 656.212, 656.214, 656.222, 656.225, 656.245, 656.262, 656.267, 656.268, 656. 273, 656.726, 656.790
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0003 Applicability of Rules

(1) These rules apply to the rating of permanent disability under ORS chapter 656 and to all claims closed on or after the effective date of these rules for workers medically stationary on or after June 7, 1995.

(2) The rules adopted by WCD Administrative Order 93-056 apply to the rating of permanent disability for workers

medically stationary on or after July 1, 1990 but before June 7, 1995, except as otherwise provided in 1995 Oregon Laws, chapter 332.

(3) The rules adopted by WCD Administrative Order 6-1988 apply to the rating of permanent disability for workers medically stationary before July 1, 1990, except as otherwise provided in 1995 Oregon Laws, chapter 332.

(4) For the purpose of reconsideration of claim closure under ORS 656.268, the rules in effect on the date of issuance of the appealed notice of closure apply to the rating of permanent disability for workers medically stationary after July 1, 1990, except as otherwise provided in 1995 Oregon Laws, chapter 332.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.273, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0005 Definitions

As used in OAR 436-035-0001 through 436-035-0500, unless the context requires otherwise:

(1) "Activities of daily living (ADL)" include, but are not limited to, the following personal activities required by an individual for continued well-being: eating/nutrition; self-care and personal hygiene; communication and cognitive functions; and physical activity, e.g., standing, walking, kneeling, hand functions, etc.

(2) "Ankylosis" means a bony fusion, fibrous union, or arthrodesis of a joint. Ankylosis does not include pseudarthrosis or articular arthropathies.

(3) "Date of issuance" means the mailing date of a notice of closure or Order on Reconsideration under ORS 656.268 and ORS 656.283(6).

(4) "Dictionary of Occupational Titles" or (DOT) means the publication of the same name by the U.S. Department of Labor, Fourth Edition Revised 1991.

(5) "Direct medical sequela" means a condition that is clearly established medically and originates or stems from an accepted condition. For example: The accepted condition is low back strain with herniated disc at L4-5. The worker develops permanent weakness in the leg and foot due to the accepted condition. The weakness is considered a "direct medical sequela".

(6) "Earning capacity" means impairment as modified by age, education, and adaptability.

(7) "Irreversible findings" for the purposes of these rules are:

(a) Arm

(A) Arm angulation

(B) Radial head resection

(C) Shortening

(b) Eye

(A) Enucleation

(B) Lens implant

(C) Lensectomy

(c) Gonadal: Loss of gonads resulting in absence of, or an abnormally high, hormone level.

(d) Hand

(A) Carpal bone fusion

(B) Carpal bone removal

(e) Kidney: Nephrectomy

(f) Leg

(A) Knee angulation

(B) Length discrepancy

(C) Meniscectomy

(D) Patellectomy

(g) Lung: Lobectomy

(h) Shoulder

(A) Acromionectomy

(B) Clavicle resection

(i) Spine

(A) Compression, spinous process, pedicle, laminae, articular process, odontoid process, and transverse process fractures

(B) Diskectomy

(C) Laminectomy

(j) Spleen: Splenectomy

(k) Urinary tract diversion

(A) Cutaneous ureterostomy without intubation

(B) Nephrostomy or intubated uresterostomy

(C) Uretero-Intestinal

(L) Other

(A) Amputations/resections

(B) Ankylosed/fused joints

(C) Displaced pelvic fracture ("healed" with displacement)

(D) Loss of opposition

(E) Organ transplants (heart, lung, liver, kidney)

(F) Prosthetic joint replacements

(8) "Medical arbiter" means a physician under ORS 656.005(12)(b)(A) appointed by the director under OAR 436-010-0330.

(9) "Offset" means to reduce a current permanent partial disability award, or portions of the award, by a prior Oregon workers' compensation permanent partial disability award from a different claim.

(10) "Physician's release" means written notification, provided by the attending physician to the worker and the worker's employer or insurer, releasing the worker to work and describing any limitations the worker has.

(11) "Preexisting condition"

(a) **Injury claims.** For all industrial injury claims with a date of injury on or after Jan. 1, 2002, "preexisting condition" means a condition that:

(A) Is arthritis or an arthritic condition; or

(B) Was treated or diagnosed before:

(i) The initial injury in a claim for an initial injury or omitted condition;

(ii) The onset of the new medical condition in a claim for a new medical condition; or

(iii) The onset of the worsened condition in a claim for an aggravation under ORS 656.273 or 656.278.

(b) **Occupational disease claims.** For all occupational disease claims with a date of injury on or after Jan. 1, 2002, "preexisting condition" means a condition that precedes the onset of the claimed occupational disease, or precedes a claim for worsening under ORS 656.273 or 656.278.

(12) "Preponderance of medical evidence" or "opinion" does not necessarily mean the opinion supported by the greater number of documents or greater number of concurrences; rather it means the more probative and more reliable medical opinion based upon factors including, but not limited to, one or more of the following:(a) The most accurate history,

(b) The most objective findings,

(c) Sound medical principles, or

(d) Clear and concise reasoning.

(13) "Redetermination" means a reevaluation of disability under ORS 656.267, 656.268(10), 656.273, and 656.325.

(14) "Regular work" means the job the worker held at the time of injury.

(15) "Scheduled disability" means a compensable permanent loss of use or function that results from injuries to those body parts listed in ORS 656.214(3)(a) through (5).

(16) "Social-vocational factors" means age, education, and adaptability factors under ORS 656.726(4)(f).

(17) "Superimposed condition" means a condition that arises after the compensable injury or disease that contributes to the worker's overall disability or need for treatment but is not the result of the original injury or disease. Disability from a superimposed condition is not rated. For example: The compensable injury results in a low back strain. Two months after the injury, the worker becomes pregnant (non-work related). The pregnancy is considered a "superimposed condition."

(18) "Unscheduled disability" means permanent loss of earning capacity as a result of a compensable injury, as described in these rules and arising from those losses under OAR 436-035-0330 through 436-035-0450.

(19) "Work disability," for the purposes of determining permanent disability, means impairment as modified by age, education, and adaptability to perform the job at which the worker was injured.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.267, 656.268, 656.273, 656.325, 656.726
Hist.: Amended 1/29/15 as WCD Admin. Order 15-053, eff. 3/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0006 Determination of Benefits for Disability Caused by the Compensable Injury

(1) **In injury claims.** In an injury claim, permanent disability caused by the compensable injury includes disability caused by:

(a) An accepted condition;

(b) A direct medical sequela of an accepted condition; or

(c) A condition directly resulting from the work injury, except that disability caused by a consequential condition under ORS 656.005(7)(a)(A), a combined condition under 656.005(7)(a)(B), or a preexisting condition under 656.225 is only awarded if the consequential, combined, or preexisting condition is accepted.

(2) **In new or omitted condition claims.** In a new or omitted condition claim, permanent disability caused by the compensable injury includes disability caused by:

(a) An accepted new or omitted condition; or

(b) A direct medical sequela of an accepted new or omitted condition.

(3) **In aggravation claims.** In an aggravation claim, permanent disability caused by the compensable injury includes disability caused by:

(a) An accepted worsened condition; or

(b) A direct medical sequela of an accepted worsened condition.

(4) **In occupational disease claims.** In an occupational disease claim, permanent disability caused by the compensable injury includes disability caused by:

(a) An accepted occupational disease; or

(b) A direct medical sequela of an accepted occupational disease.

Stat. Auth.: ORS 656.726
Stats. Impltd.: ORS 656.005, 656.214, 656.225, 656.268, 656.726, 656.802
Adopted 1/29/15 as WCD Admin. Order 15-053, eff. 3/1/15

436-035-0007 General Principles

(1) Eligibility for impairment.

(a) **Eligibility, generally.** A worker is eligible for an award for impairment if:

(A) The worker suffers permanent loss of use or function of a body part or system;

(B) The loss is established by a preponderance of medical evidence based upon objective findings of impairment; and

(C) The loss is caused in any part by the compensable injury.

(b) **Apportionment.** A worker's award for impairment is limited to the amount of impairment caused by the compensable injury.

(A) If loss of use or function of a body part or system is entirely caused by the compensable injury, the worker is eligible for the full award provided for the loss under the rating standards in this division of rules.

(B) If loss of use or function of a body part or system is partly caused by the compensable injury, the following provisions apply:

(i) The worker is eligible for an award for impairment for:

(I) The portion of the loss caused by the compensable injury; and

(II) The portion of the loss caused by a condition that does not qualify as a preexisting condition but that existed before the initial injury in an initial injury or omitted condition claim, before the onset of the accepted new medical condition in a new condition claim, or before the onset of the accepted worsened condition in an aggravation claim.

(ii) The worker is not eligible for an award for impairment for the portion of the loss caused by:

(I) A denied condition;

(II) A superimposed condition; or

(III) A preexisting condition, as defined by OAR 436-035-0005(11) and ORS 656.005(24), unless the preexisting condition is otherwise compensable.

(C) If loss of use or function of a body part or system is not caused in any part by the compensable injury, the loss is not due to the compensable injury and the worker is not eligible for an award for impairment.

(2) **Eligibility for work disability.** An award for impairment is modified by the factors of age, education, and adaptability if the worker is eligible for an award for work disability. A worker is eligible for an award for work disability if:

(a) The worker is eligible for an award for impairment;

(b) An attending physician or authorized nurse practitioner has not released the worker to the job held at the time of injury;

(c) The worker has not returned to the job held at the time of injury; and

(d) The worker is unable to return to the job held at the time of injury because the worker has a permanent work restriction that is caused in any part by the compensable injury.

(3) When a new or omitted medical condition has been accepted since the last arrangement of compensation, the extent of permanent disability must be redetermined.

(a) Redetermination includes the rating of the new impairment attributed to the accepted new or omitted medical condition and the reevaluation of the worker's social-vocational factors. The following applies to claims with a date of injury on or after Jan. 1, 2005:

(A) When there is a previous work disability award and there is no change in the worker's restrictions but impairment values increase, work disability must be awarded based on the additional impairment.

(B) When there is not a previous work disability award but the accepted new or omitted medical condition creates restrictions that do not allow the worker to return to regular work, the work disability must be awarded based on any previous and current impairment values.

(b) When performing a redetermination of the extent of permanent disability under this section, the amount of impairment caused by a condition other than the accepted new or omitted condition is not reevaluated and is given the same impairment value as established at the last arrangement of compensation.

(4) When a worker has a prior award of permanent disability under Oregon workers' compensation law, disability is determined under OAR 436-035-0015 (offset) for purposes of determining disability only as it pertains to multiple Oregon workers' compensation claims.

(5) Establishing impairment.

(a) Impairment is established based on objective findings of the attending physician under ORS 656.245(2)(b)(C) and OAR 436-010-0280.

(b) On reconsideration, when a medical arbiter is used, impairment is established based on objective findings of the medical arbiter, except where a preponderance of the medical evidence demonstrates that different findings by the attending physician are more accurate and should be used.

(c) A determination that loss of use or function of a body part or system is due to the compensable injury is a finding regarding the worker's impairment.

(d) A determination that loss of use or function of a body part or system is due to the compensable injury must be established by the attending physician or medical arbiter.

(6) Objective findings made by a consulting physician or other medical providers (e.g., occupational or physical therapists) at the time of closure may be used to determine impairment if the worker's attending physician concurs with the findings.

(7) If there is no measurable impairment under these rules, no award of permanent partial disability is allowed.

(8) Pain is considered in the impairment values in these rules to the extent that it results in valid measurable impairment. For example: The medical provider determines that giveaway weakness is due to pain attributable to the compensable injury. If there is no measurable impairment, no award of permanent disability is allowed for pain. To the extent that pain results in disability greater than that evidenced by the measurable impairment, including the disability due to expected waxing and waning of the worker's compensable injury, this loss of earning capacity is considered and valued under OAR 436-035-0012 and is included in the adaptability factor.

(9) Methods used by the examiner for making findings of impairment are the methods described in these rules and further outlined in Bulletin 239, and are reported by the physician in the form and format required by these rules.

(10) Range of motion is measured using the goniometer, except when measuring spinal range of motion; then an inclinometer must be used. Reproducibility of abnormal motion is used to validate optimum effort.

(a) For obtaining goniometer measurements, center the goniometer on the joint with the base in the neutral position. Have the worker actively move the joint as far as possible in each motion with the arm of the goniometer following the motion. Measure the angle that subtends the arc of motion. To

determine ankylosis, measure the deviation from the neutral position.

(b) There are three acceptable methods for measuring spinal range of motion: the simultaneous application of two inclinometers, the single fluid-filled inclinometer, and an electronic device capable of calculating compound joint motion. The examiner must take at least three consecutive measurements of mobility, which must fall within 10% or 5 degrees (whichever is greater) of each other to be considered consistent. The measurements must be repeated up to six times to obtain consecutive measurements that meet these criteria. Inconsistent measurements may be considered invalid and that portion of the examination disqualified. If acute spasm is noted, the worker should be reexamined after the spasm resolves.

(11) Validity is established for findings of impairment under the criteria noted in these rules and further outlined in Bulletin 239, unless the validity criteria for a particular finding is not addressed, or is determined by physician opinion to be medically inappropriate for a particular worker. Upon examination, findings of impairment that are determined to be ratable under these rules are rated unless the physician determines the findings are invalid. When findings are determined invalid, the findings receive a value of zero. If the validity criteria are not met but the physician determines the findings are valid, the physician must provide a written rationale, based on sound medical principles, explaining why the findings are valid. For purposes of this rule, the straight leg raising validity test (SLR) is not the sole criterion used to invalidate lumbar range of motion findings.

(12) Except for contralateral comparison determinations under OAR 436-035-0011(3), loss of opposition determination under OAR 436-035-0040, averaging muscle values under OAR 436-035-0011(8), and impairment determined under ORS 656.726(4)(f), only impairment values listed in these rules are to be used in determining impairment. Prorating or interpolating between the listed values is not allowed. For findings that fall between the listed impairment values, the next higher appropriate value is used for rating.

(13) Values found in these rules consider the loss of use, function, or earning capacity directly associated with the compensable injury. When a worker's impairment findings do not meet the threshold (minimum) findings established in these rules, no value is granted.

(a) Not all surgical procedures result in loss of use, function, or earning capacity. Some surgical procedures improve the use and function of body parts, areas, or systems or ultimately may contribute to an increase in earning capacity. Accordingly, not all surgical procedures receive a value under these rules.

(b) Not all medical conditions or diagnoses result in loss of use, function, or earning capacity. Accordingly, not all medical conditions or diagnoses receive a value under these rules.

(14) Waxing and waning of signs or symptoms related to a worker's compensable injury are already contemplated in the values provided in these rules. There is no additional value granted for the varying extent of waxing and waning of the compensable injury. Waxing and waning means there is not an actual worsening of the condition under ORS 656.273.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.245, 656.267, 656.268, 656.273, 656.726
Hist.: Amended 1/29/15 as WCD Admin. Order 15-053, eff. 3/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0008 Calculating Disability Benefits (Dates of Injury prior to 1/1/2005)

(1) Scheduled disability with a date of injury prior to January 1, 2005, is rated on the permanent loss of use or function of a body part caused by a compensable injury. To calculate the scheduled impairment benefit, use the following steps:

(a) Determine the percent of scheduled impairment using the impairment values found in OAR 436-035-0019 through 436-035-0260, and the applicable procedures within these rules.

(b) Multiply the result in (a) by the maximum degrees, under ORS 656.214, for the injured body part.

(c) Multiply the result from (b) by the statutory dollar rate under ORS 656.214 and illustrated in Bulletin 111.

(d) The result from (c) is the scheduled impairment benefit. If there are multiple extremities with impairment then each is determined and awarded separately, including hearing and vision loss.

Example: Scheduled impairment benefit

0.12 Scheduled impairment percent (12%)

x 192 Maximum degrees for the body part

= 23.04 Degrees of scheduled disability

x $559.00 Statutory dollar rate per degree

= $12,879.36 Scheduled impairment benefit

(2) Unscheduled disability with a date of injury prior to January 1, 2005, is rated on the permanent loss of use or function of a body part or system caused by a compensable injury, as modified by the factors of age, education, and adaptability.

(a) To calculate the unscheduled impairment benefit when the worker returns or is released to regular work according to OAR 436-035-0009(3), use the following steps.

(A) Determine the percent of unscheduled impairment using the impairment values found in OAR 436-035-0019 and OAR 436-035-0330 through 436-035-0450, and the applicable procedures within these rules.

(B) Multiply the result in (A) by the maximum degrees for unscheduled impairment.

(C) Multiply the result in (B) by the statutory dollar rate under ORS 656.214 and illustrated in Bulletin 111.

(D) The result in (C) is the unscheduled impairment benefit.

Example: Unscheduled impairment benefit (worker returns/is released to regular work)

0.12 Unscheduled impairment percent (12%)

x 320 Maximum degrees for unscheduled impairment

= 38.40 Degrees of unscheduled disability

x $184.00 Statutory dollar rate per degree

= $7,065.60 Unscheduled impairment benefit

(b) To calculate the unscheduled disability benefit when the worker does not return or is not released to regular work according to OAR 436-035-0009(3), use the following steps.

(A) Determine the percent of unscheduled impairment using the impairment values found in OAR 436-035-0019 and OAR 436-035-0330 through 436-035-0450, and the applicable procedures within these rules.

(B) Determine the social-vocational factor, under OAR 436-035-0012, and add it to (A).

(C) Multiply the result from (B) by the maximum degrees for unscheduled impairment.

(D) Multiply the result from (C) by the statutory dollar rate for unscheduled impairment under ORS 656.214.

(E) The result from (D) is the unscheduled impairment benefit.

Example:

Unscheduled impairment benefit (worker does not return/released to regular work)

0.12 Unscheduled impairment percentage (12%)

+ 6% Social-vocational factor

= 18% Unscheduled impairment

X 320 Maximum degrees for unscheduled impairment

= 57.6 Degrees of unscheduled disability

X $184.00 Statutory dollar rate per degree

= $10,598.40 Unscheduled impairment benefit

Stat. Auth.: ORS 656.726:
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726:
Hist.: Amended 1/29/15 as WCD Admin. Order 15-053, eff. 3/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0009 Calculating Disability Benefits (Date of Injury on or after 1/1/2005)

(1) Permanent impairment is expressed as a percent of the whole person and the impairment value will not exceed 100% of the whole person.

(2) If the impairment results from injury to more than one extremity, area, or system, the whole person values for each are combined (not added) to arrive at a final impairment value.

(3) Only permanent impairment is rated for those workers with a date of injury prior to January 1, 2006, and who:

(a) Return to and are working at their regular work on the date of issuance;

(b) The attending physician or authorized nurse practitioner releases to regular work and the work is available, but the worker fails or refuses to return to that job; or

(c) The attending physician or authorized nurse practitioner releases to regular work, but the worker's employment is terminated for cause unrelated to the injury.

(4) Only permanent impairment is rated for those workers with a date of injury on or after January 1, 2006, and who have been released or returned to regular work by the attending physician or authorized nurse practitioner.

(5) To calculate the impairment benefit due to the worker, use the following steps:

(a) Determine the percent of impairment under these rules.

(b) Multiply the percent of impairment determined in (a) by 100 per ORS 656.214.

(c) Multiply the result from (b) by the state's average weekly wage at the time of injury as defined by ORS 656.005 and illustrated in Bulletin 111.

(d) The result in (c) is the total impairment benefit, which is paid regardless of the worker's return to work status. In the absence of social-vocational factoring as a result of the worker's return to work status, this is also the permanent partial disability award.

Example: Impairment benefit (paid regardless of return to work status)

	0.12	Impairment percent (12%)
x	100	
x	$688.56	State's average weekly wage (SAWW)
=	$8,262.72	Impairment benefit

(6) If the worker has not met the return or release to regular work criteria in section (3) or (4) of this rule, the worker receives both an impairment and work disability benefit, and the total permanent partial disability award is calculated as follows.

(a) Determine the percent of impairment as a whole person (WP) value under these rules.

(b) Determine the social-vocational factor, under OAR 436-035-0012, and add it to (a).

(c) Multiply the result from (b) by 150 per ORS 656.214.

(d) Multiply the result from (c) by worker's average weekly wage as calculated under ORS 656.210.

(A) Supplemental disability is not considered in the determination of the worker's average weekly wage when calculating work disability.

(B) The worker's average weekly wage can be no less than 50% and no more than 133% of the state's average weekly wage at the time of injury when determining work disability benefits.

(e) Add the result from (d) to the impairment benefit value, which would be calculated using the method in section (4) of this rule.

(f) The result from (e) is the permanent partial disability award that would be due the worker.

Example: Work disability benefit and PPD award (no return to work)

	0.12	Impairment percentage – WP percentage (12%)
+	0.06	Social-vocational factor (6%)
=	0.18	Work disability percentage (18%)
x	150	
x	$410.00	Worker's average weekly wage at injury
=	$11,070.00	Work disability benefit
+	$8,262.72	Impairment benefit

=	$19,332.72	PPD award

Stat. Auth.: ORS 656.726:
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0011 Determining Percent of Impairment

(1) The total impairment rating for a body part cannot be more than 100% of the body part.

(2) When rating disability the movement in a joint is measured in active degrees of motion. Impairment findings describing lost ranges of motion are converted to retained ranges of motion by subtracting the measured loss from the normal of full ranges established in these rules.

(a) Range of motion values for each direction in a single joint are first added, then combined with other impairment findings.

Example: Range of motion of elbow	Arm Impairment
flexion to 120º	8%
extension to 30º	6%
Add	14%
Other Impairment Values	
Weakness	7%
Prosthetic radial head replacement	10%
Combine 14 and 10 = 23	
23 and 7 = 28% total Arm Impairment	

(b) Range of motion values for multiple joints in a single body part (e.g., of a finger) are determined by finding the range of motion values for each joint (e.g., MCP, PIP, DIP) and combining those values for an overall loss of range of motion value for that body part. This value is then combined with other impairment values.

(3) The range of motion or laxity (instability) of an injured joint is compared to and valued proportionately to the contralateral joint except when the contralateral joint has a history of injury or disease or when either joint's range of motion is zero degrees or is ankylosed. The strength of an injured extremity, shoulder, or hip may be compared to and valued proportionately to the contralateral body part except when the contralateral body part has a history of injury or disease.

Instability example:

The injured knee is reported to have severe instability of the anterior cruciate ligament. The standards grant an impairment value of 15% for severe instability of the anterior cruciate ligament.

The contralateral knee is reported to have mild instability of the anterior cruciate ligament. The standards grant an impairment value of 5% for mild instability of the anterior cruciate ligament.

A proportion is established by subtracting the contralateral instability of 5% from the 15% for the injured joint which = 10% impairment for the instability.

Strength example:

The injured deltoid muscle is reported to have 3/5 strength. The standards note 3/5 strength = 50%.

The contralateral deltoid muscle is reported to have 4+/5 strength. The standards note 4+/5 strength = 10%.

A proportion is established by subtracting the contralateral strength of 10% from the 50% for the injured arm which = 40%. This percentage is then used to determine the loss of strength for the injured deltoid.

Range of motion examples:

Flexion (knee): 80° retained on injured side, the contralateral joint flexes to 140°.

A proportion is established to determine the expected degrees of flexion since 140° has been established as normal for this worker.

One method of determining this proportion is: 80/140 = X/150.

X = expected retained range of motion compared to the established norm of 150° upon which flexion is determined under these rules. X, in this case, equals 86°.

86° of retained flexion of the knee is calculated under these rules, after rounding, to 23% impairment.

Extension (knee): 35° retained on injured side, the contralateral joint extends to 15°. First, find the complement, i.e., 150 - 15 =135 (uninjured) and 150 - 35 = 115 (injured). Next, using the same method as for flexion, 115/135 = X/150, or, X = 127.77. Then, revert back, so, 150 - 127.77 = 22.23 rounded to 22° for an impairment value of 9%.

(a) If the motion of the injured or contralateral joint exceeds the values for ranges of motion established under these rules, the values established under these rules are maximums used to establish impairment.

(b) When the contralateral joint has a history of injury or disease, the findings of the injured joint are valued based upon the values established under these rules.

(4) Specific impairment findings (e.g., weakness, reduced range of motion, etc.) are awarded in whole number increments. This may require rounding non-whole number percentages and contralateral comparison degrees of motion for given impairment findings before combining with any other applicable impairment value.

(a) Except for subsection (b) of this section, before combining, the sum of the impairment values is rounded to the nearest whole number. For the decimal portion of the number, point 5 and above is rounded up, below point 5 is rounded down.

Example:

Range of motion of the wrist		Impairment
Dorsiflexion 36º	=	3.80%
Flexion 63º	=	1.40%
Radial deviation 16º	=	0.80%
Deviation 7º	=	4.30%
Add range of motion findings in a single joint. (Sum of impairment values)		10.30%

Round to nearest whole number	10%

(b) When the sum of impairment values is greater than zero and less than 0.5, a value of 1% will be granted.

Example:

Range of motion of the wrist		**Impairment**
Dorsiflexion 60º	=	0.00%
Flexion 69º	=	0.20%
Radial deviation 19º	=	0.20%
Ulnar deviation 30º	=	0.00%
Add range of motion findings in a single joint.	=	0.40%
Since the value is greater than zero and less than 0.5%, the award is 1% of wrist. (sum of impairment values)	=	1.00%

(5) If there are impairment findings in two or more body parts in an extremity, the total impairment findings in the distal body part are converted to a value in the most proximal body part under the applicable conversion chart in these rules. This conversion is done prior to combining impairment values for the most proximal body part.

Example:

Wrist	**Range of motion**	
	Extension:	50º = 2%
	Flexion:	40º = 5%
	Add	7%
Elbow	Range of motion	
	Flexion:	110º = 10% arm

Convert (wrist) to arm per OAR 436-035-0090: 7% wrist = 6% arm
Combine 10% with 6% = 15% arm

(6) Except as otherwise noted in these rules, impairment values to a given body part, area, or system are combined as follows:

(a) The combined value is obtained by inserting the values for A and B into the formula A + B(1.0 - A). The larger of the two numbers is A and the smaller is B. The whole number percentages of impairment are converted to their decimal equivalents (e.g., 12% converts to .12; 3% converts to .03). The resulting percentage is rounded to a whole number as determined in section (1) of this rule. Upon combining the largest two percentages, the resulting percentage is combined with any lesser percentage(s) in descending order using the same formula until all percentages have been combined prior to performing further computations. After the calculations are completed, the decimal result is then converted back to a percentage equivalent. Example: .12 + .03(1.0 - .12) =.12 + .03(.88) =.12 + .0264 =.1464 = 14.6 = 15.

Example:

Impairment of the wrist/hand	**Impairment**
Loss of range of motion	= 6% of the wrist/hand
Weakness of wrist	= 9% of the wrist/hand
Carpal bone surgery	= 5% of the wrist/hand

Combine 9 and 6 = 14; then combine 14 and 5 = 18% total impairment wrist/hand

(b) Impairment values for a given body part, area, or system must be combined before combining with other impairment values. If the given body part is an upper or lower extremity, ear(s), or eye(s) then the impairment value is to be converted to a whole person value before combining with other impairment values, except when the date of injury for the claim is prior to Jan. 1, 2005.

Example:

Low back	**Impairment**
Range of motion	10%
Surgery	9%
Fractured vertebrae	7%

Combine 10 and 9 = 18;
Then combine 18 and 7 = 24% low back (combined value)

Arm	
Range of motion	5%
Surgery	8%
Combine 8 and 5 =	13% arm (combined value)

Convert 13% arm to 8% whole person
Overall impairment:
Combined 24% (low back) with 8% (arm) = 30% impairment

(7) Loss of strength is determined using the modified 0 to 5 international grading system described below. The grade of strength is reported by the physician and assigned a percentage value from the table in subsection (a) of this section. The impairment value of the involved nerve, which supplies (innervates) the weakened muscle, is multiplied by this value. Grades identified as "++" or "--" are considered either a "+" or "-", respectively.

(a) The grading is valued as follows:

Grade	Description	Percent
5/5:	The worker retains range of motion against gravity with full resistance applied.	0%
5-/5		5%
4+/5		10%
4/5:	The worker retains range of motion against gravity with some resistance applied.	20%
4-/5		30%
3+/5		40%
3/5:	The worker retains range of motion against gravity without resistance applied	50%
3-/5		60%
2+/5		70%
2/5:	The worker retains range of motion with gravity eliminated.	75%
2-/5		80%
1+/5		85%
1/5:	The worker has evidence of slight muscle contractility; no joint motion.	90%
1-/5		95%
0/5:	The worker has no evidence of muscle contractility	100%

(b) When a physician reports a loss of strength with muscle action (e.g., flexion, extension, etc.) or when only the affected muscle(s) is identified, anatomy texts or the AMA Guides to the Evaluation of Permanent Impairment may be referenced to identify the specific muscle(s), peripheral nerve(s) or spinal nerve root(s) involved. A copy of the standards referenced in this rule is available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301, 503-947-7810.

(8) For muscles supplied (innervated) by the same nerve, the loss of strength is determined by averaging the percentages of impairment for each involved muscle to arrive at a single percentage of impairment for the involved nerve.

Example: Forearm

Radial nerve (50%) supplies (innervates):

Muscles	(grade)	(%)		(nerve)	
Supinator	4/5 =	20%	x	.50	= 10%
Extensor carpi radialis	3/5 =	50%	x	.50	= 25%
Extensor carpi ulnaris	4/5 =	20%	x	.50	= 10%
	Add				45%

Average 45% ÷ 3 = 15% impairment to radial nerve

(9) When multiple nerves have impairment findings found under these rules, these impairment values are first combined for an overall loss of strength value for the body part before combining with other impairment values.

(10) When a joint is ankylosed in more than one direction or plane, the largest ankylosis value is used for rating the loss or only one of the values is used if they are identical. This value is granted in lieu of all other range of motion or ankylosis values for that joint.

Stat. Auth.: ORS 656.726:
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0012 Social-Vocational Factors (Age/Education/Adaptability) and the Calculation of Work Disability

(1) Social-vocational factors.

(a) If a worker is eligible for an award for work disability, the factors of age, education, and adaptability are determined under this rule and used to calculate the worker's social-vocational factor. The social-vocational factor is determined according to the steps described in section (15) of this rule and is used in the calculation of permanent disability benefits.

(b) When the date of injury is prior to Jan. 1, 2005, the worker must have ratable unscheduled impairment under OAR 436-035-0019 or OAR 436-035-0330 through 436-035-0450.

(2) The age factor is based on the worker's age at the date of issuance and has a value of 0 or +1.

(a) Workers age 40 and above receive a value of + 1.

(b) Workers less than 40 years old receive a value of 0.

(3) The education factor is based on the worker's formal education and specific vocational preparation (SVP) time at the date of issuance. These two values are determined by sections (4) and (5) of this rule, and are added to give a value from 0 to +5.

(4) A value of a worker's formal education is given as follows:

(a) Workers who have earned or acquired a high school diploma or general equivalency diploma (GED) are given a neutral value of 0. For purposes of this section, a GED is a certificate issued by any certifying authority or its equivalent.

(b) Workers who have not earned or acquired a high school diploma or a GED certificate are given a value of +1.

(5) A value for a worker's specific vocational preparation (SVP) time is given based on the jobs successfully performed by the worker in the five years prior to the date of issuance. The SVP value is determined by identifying these jobs and locating their SVP in the Dictionary of Occupational Titles (DOT) or a specific job analysis. The job with the highest SVP the worker has met is used to assign a value according to the following table:

SVP	Value	Training time
1	4	Short demonstration
2	4	Short demonstration up to 30 days
3	3	30+ days - 3 months
4	3	3+ months - 6 months
5	2	6+ months - 1 year
6	2	1+ year - 2 years
7	1	2+ years - 4 years
8	1	4+ years - 10 years
9	1	10+ years

A copy of the Dictionary of Occupational Titles referenced in this rule is available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301, 503-947-7810.

(a) For the purposes of this rule, SVP is defined as the amount of time required by a typical worker to acquire the knowledge, skills, and abilities needed to perform a specific job.

(b) When a job is most accurately described by a combination of DOT codes, use all applicable DOT codes. If a preponderance of evidence establishes that the requirements of a specific job differ from the DOT descriptions, one of the following may be substituted for the DOT descriptions if it more accurately describes the job:

(A) A specific job analysis as described under OAR 436-120-0410, which includes the SVP time requirement; or

(B) A job description that the parties agree is an accurate representation of the physical requirements, as well as the tasks and duties, of the worker's regular job-at-injury.

(c) A worker is presumed to have met the SVP training time after completing employment with one or more employers in that job classification for the time period specified in the table.

(d) A worker meets the SVP for a job after successfully completing an authorized training program, on-the-job training, vocational training, or apprentice training for that job classification. College training organized around a specific vocational objective is considered specific vocational training.

(e) For those workers who have not met the specific vocational preparation training time for any job, a value of +4 is granted.

(6) The values obtained in sections (4) and (5) of this rule are added to arrive at a final value for the education factor.

(7) The adaptability factor is an evaluation of the extent to which the compensable injury has permanently restricted the worker's ability to perform work activities. The adaptability factor is determined by performing a comparison of the worker's base functional capacity to the worker's residual functional capacity, under sections (8) through (14) of this rule, and is given a value from +1 to +7.

(8) For purposes of determining adaptability, the following definitions apply:

(a) "Base functional capacity" (BFC) is established under section (9) of this rule and means an individual's demonstrated ability to perform work-related activities before the date of injury or disease.

(b) "Residual functional capacity" (RFC) is established under section (10) of this rule and means an individual's remaining ability to perform work-related activities at the time the worker is medically stationary.

(c) "Sedentary restricted" means the worker only has the ability to carry or lift dockets, ledgers, small tools, and other items weighing less than 10 pounds. A worker is also sedentary restricted if the worker can perform the full range of sedentary activities, but with restrictions.

(d) "Sedentary (S)" means the worker has the ability to occasionally lift or carry dockets, ledgers, small tools and other items weighing 10 pounds.

(e) "Sedentary/light (S/L)" means the worker has the ability to do more than sedentary activities, but less than the full range of light activities. A worker is also sedentary/light if the worker can perform the full range of light activities, but with restrictions.

(f) "Light (L)" means the worker has the ability to occasionally lift 20 pounds and can frequently lift or carry objects weighing up to 10 pounds.

(g) "Medium/light (M/L)" means the worker has the ability to do more than light activities, but less than the full range of medium activities. A worker is also medium/light if the worker can perform the full range of medium activities, but with restrictions.

(h) "Medium (M)" means the worker can occasionally lift 50 pounds and can lift or carry objects weighing up to 25 pounds frequently.

(i) "Medium/heavy (M/H)" means the worker has the ability to do more than medium activities, but less than the full range of heavy activities. A worker is also medium/heavy if the worker can perform the full range of heavy activities, but with restrictions.

(j) "Heavy (H)" means the worker has the ability to occasionally lift 100 pounds and the ability to frequently lift or carry objects weighing 50 pounds.

(k) "Very Heavy (V/H)" means the worker has the ability to occasionally lift in excess of 100 pounds and the ability to frequently lift or carry objects weighing more than 50 pounds.

(l) "Restrictions" means that, by a preponderance of medical opinion, the worker is permanently limited from:

(A) Sitting, standing, or walking less than two hours at a time; or

(B) Working the same number of hours as were worked at the time of injury, including any regularly worked overtime hours; or

(C) Frequently performing at least one of the following activities: stooping, bending, crouching, crawling, kneeling, twisting, climbing, balancing, reaching, pushing, or pulling; or

(D) Frequently performing at least one of the following activities involving the hand: fine manipulation, squeezing, or grasping.

(m) "Occasionally" means the activity or condition exists up to 1/3 of the time.

(n) "Frequently" means the activity or condition exists up to 2/3 of the time.

(o) "Constantly" means the activity or condition exists 2/3 or more of the time.

(9) **Base Functional Capacity.** Base functional capacity (BFC) is established by using the following classifications: sedentary (S), light (L), medium (M), heavy (H), and very heavy (VH) as defined in section (8) of this rule. The strength

classifications are found in the Dictionary of Occupational Titles (DOT). Apply the subsection in this section that most accurately describes the worker's base functional capacity.

(a) The highest strength category of the jobs successfully performed by the worker in the five years prior to the date of injury.

(A) A combination of DOT codes when they describe the worker's job more accurately.

(B) A specific job analysis, which includes the strength requirements, may be substituted for the DOT descriptions if it most accurately describes the job. If a job analysis determines that the strength requirements are in between strength categories then use the higher strength category.

(C) A job description that the parties agree is an accurate representation of the physical requirements, as well as the tasks and duties, of the worker's regular job-at-injury. If the job description determines that the strength requirements are in between strength categories then use the higher strength category.

(b) A second-level physical capacity evaluation as defined in OAR 436-010-0005 and 436-009-0060(2) performed prior to the date of the work injury.

(c) For those workers who do not meet the requirements under section (5) of this rule, and who have not had a second-level physical capacity evaluation performed prior to the work injury or disease, their prior strength is based on the worker's job at the time of injury.

(d) When a worker's highest prior strength has been reduced as a result of an injury or condition which is not an accepted Oregon workers' compensation claim the base functional capacity is the highest of:

(A) The job at injury; or

(B) A second-level physical capacities evaluation as defined in OAR 436-010-0005 and 436-009-0060(2) performed after the injury or condition which was not an accepted Oregon workers' compensation claim but before the current work related injury.

(10) **Residual Functional Capacity.** Residual functional capacity (RFC) is established by using the following classifications: restricted sedentary (RS), sedentary (S), sedentary/light (S/L), light (L), medium/light (M/L), medium (M), medium/heavy (M/H), heavy (H), and very heavy (VH) and restrictions as defined in section (8) of this rule.

(a) **Medical findings.** Residual functional capacity is evidenced by the attending physician's release unless a preponderance of medical opinion describes a different RFC.

(b) **Other medical opinions.** For the purposes of subsection (a) of this section, the other medical opinion must include at least a second-level physical capacity evaluation (PCE) or work capacity evaluation (WCE) as defined in OAR 436-010-0005 and 436-009-0060(2) or a medical evaluation that addresses the worker's capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, stooping, bending, kneeling, crouching, crawling, and reaching. If multiple levels of lifting and carrying are measured, an overall analysis of the worker's lifting and carrying abilities should be provided in order to allow an accurate determination of these abilities. When the worker fails to cooperate or complete a residual functional capacity (RFC) evaluation, the evaluation must be rescheduled or the evaluator must estimate the worker's RFC as if the worker had cooperated and used maximal effort.

(c) **Work capacity diminished by a superimposed, preexisting, or denied condition.** Residual functional capacity is a measure of the extent to which the worker's capacity to perform work is diminished by the compensable injury. If the worker's capacity to perform work is diminished by a superimposed, preexisting, or denied condition, the worker's residual functional capacity must be adjusted based on an estimate of what the worker's capacity to perform work would be if it had not been diminished by the superimposed, preexisting, or denied condition.

(d) **When the worker is not medically stationary.** Except for a claim closed under ORS 656.268(1)(c), if a worker is not medically stationary, residual functional capacity is determined based on an estimate of what the worker's capacity to perform work would be if measured at the time the worker is likely to become medically stationary.

(e) When the worker is not medically stationary and work capacity is diminished by a superimposed, preexisting, or denied condition. Except for a claim closed under ORS 656.268(1)(c), if a worker is not medically stationary and the worker's capacity to perform work is diminished by a superimposed, preexisting, or denied condition, residual functional capacity is determined based on an estimate of what the worker's capacity to perform work would be if measured at the time the worker is likely to become medically stationary and if the worker's capacity to perform work had not been diminished by the superimposed, preexisting, or denied condition.

(f) **Lifting capacity.** For the purposes of the determination of residual functional capacity, the worker's lifting capacity is based on the whole person, not an individual body part.

(g) **Injuries before Jan. 1, 2005.** If the date of injury is before Jan. 1, 2005, residual functional capacity is determined under this section and is further adjusted based on an estimate of what the worker's capacity to perform work would be if it had only been diminished by a compensable injury to the hip, shoulder, head, neck, or torso.

(11) In comparing the worker's base functional capacity (BFC) to the residual functional capacity (RFC), the values for adaptability to perform a given job are as follows:

Residual functional capacity (RFC)										
Base functional capacity (BFC) (physical demand)		RS	S	S/L	L	M/L	M	M/H	H	V/H
	S	2	1	1	1	1	1	1	1	1
	L	4	3	2	1	1	1	1	1	1
	M	6	5	4	3	2	1	1	1	1
	H	7	6	6	5	4	3	2	1	1
	V/H	7	7	6	5	4	3	2	1	1

(12) For those workers who have an RFC between two categories and who also have restrictions, the next lower classification is used. (For example, if a worker's RFC is S/L and the worker has restrictions, use S).

(13) When the date of injury is on or after Jan. 1, 2005, determine adaptability by finding the adaptability value for the worker's extent of total impairment on the adaptability scale below; compare this value with the residual functional capacity scale in section (11) of this rule and use the higher of the two values for adaptability.

Total impairment	Adaptability value
1-9%	1
10-19%	2
20-29%	3
30-39%	4
40-49%	5
50-59%	6
60% and over	7

(14) When the date of injury is before Jan. 1, 2005, for those workers who have ratable unscheduled impairment found in rules OAR 436-035-0019 or OAR 436-035-0330 through 436-035-0450, determine adaptability by applying the extent of total unscheduled impairment to the adaptability scale in section (13) of this rule and the residual functional capacity scale in section (11) of this rule and use the higher of the two values for adaptability.

(15) To determine the social-vocational factor value, which represents the total calculation of age, education, and adaptability, complete the following steps.

(a) Determine the appropriate value for the age factor using section (2) of this rule.

(b) Determine the appropriate value for the education factor using sections (4) and (5) of this rule.

(c) Add age and education values together.

(d) Determine the appropriate value for the adaptability factor using sections (7) through (14) of this rule.

(e) Multiply the result from step (c) by the value from step (d) for the social-vocational factor value.

(16) Prorating or interpolating between social-vocational values is not allowed. All values must be expressed as whole numbers.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
Amended 1/29/15 as WCD Admin. Order 15-053, eff. 3/1/15

436-035-0013 Findings of Impairment

(1) **Findings of impairment, generally.** Findings of impairment are objective medical findings that measure the extent to which a worker has suffered permanent loss of use or function of a body part or system.

(2) **Findings of impairment when the worker is medically stationary.** If the worker is medically stationary, findings of impairment are determined by performing the following steps:

(a) In injury claims.

(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury.

(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and

(C) Establish the portion of the loss caused by:

(i) Any accepted condition;

(ii) Any direct medical sequela of an accepted condition;

(iii) Any condition directly resulting from the work injury;

(iv) Any condition that existed before the initial injury incident but does not qualify as a preexisting condition;

(v) Any preexisting condition that is not otherwise compensable;

(vi) Any denied condition; and

(vii) Any superimposed condition.

Example:

Accepted condition: Low back strain

Superimposed condition: pregnancy (mid-term)

In the closing examination, the attending physician describes range of motion findings and states that 10% of the range of motion loss is due to the accepted condition, 50% of the loss is due to a lumbar disc herniation that the attending physician determines directly results from the work injury, and 40% of the loss is due to the pregnancy. The worker is eligible for an impairment award for the 60% of the range of motion loss that is due to the low back strain and disc herniation. Under these rules, the range of motion loss is valued at 10%. 10% x .60 equals 6% impairment.

(b) In new or omitted condition claims.

(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and

(C) Establish the portion of the loss caused by:

(i) Any accepted new or omitted condition;

(ii) Any direct medical sequela of an accepted new or omitted condition;

(iii) In a new condition claim, any condition that existed before the onset of the accepted new medical condition but does not qualify as a preexisting condition;

(iv) In an omitted condition claim, any condition that existed before the initial injury incident but does not qualify as a preexisting condition;

(v) Any preexisting condition that is not otherwise compensable;

(vi) Any denied condition; and

(vii) Any superimposed condition.

(c) In aggravation claims.

(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and

(C) Establish the portion of the loss caused by:

(i) Any accepted worsened condition;

(ii) Any direct medical sequela of an accepted worsened condition;

(iii) Any condition that existed before the onset of the accepted worsened condition but does not qualify as a preexisting condition;

(iv) Any preexisting condition that is not otherwise compensable;

(v) Any denied condition; and

(vi) Any superimposed condition.

(d) In occupational disease claims.

(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and

(C) Establish the portion of the loss caused by:

(i) Any accepted occupational disease;

(ii) Any direct medical sequela of an accepted occupational disease;

(iii) Any preexisting condition that is not otherwise compensable;

(iv) Any denied condition; and

(v) Any superimposed condition.

(3) **Findings of impairment when the worker is not medically stationary.** Except for a claim closed under ORS 656.268(1)(c), if the worker is not medically stationary, findings of impairment are determined by performing the following steps:

(a) In injury claims.

(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury at the time the worker is likely to become medically stationary;

(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and

(C) Estimate the portion of the loss that is likely to be caused by:

(i) Any accepted condition;

(ii) Any direct medical sequela of an accepted condition;

(iii) Any condition directly resulting from the work injury;

(iv) Any condition that existed before the initial injury incident but does not qualify as a preexisting condition;

(v) Any preexisting condition that is not otherwise compensable;

(vi) Any denied condition; and

(vii) Any superimposed condition.

(b) In new or omitted condition claims.

(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition at the time the worker is likely to become medically stationary;

(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and

(C) Estimate the portion of the loss that is likely to be caused by:

(i) Any accepted new or omitted condition;

(ii) Any direct medical sequela of an accepted new or omitted condition;

(iii) In a new condition claim, any condition that existed before the onset of the accepted new medical condition but does not qualify as a preexisting condition;

(iv) In an omitted condition claim, any condition that existed before the initial injury incident but does not qualify as a preexisting condition;

(v) Any preexisting condition that is not otherwise compensable;

(vi) Any denied condition; and

(vii) Any superimposed condition.

(c) In aggravation claims.

(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted worsened condition or a direct medical sequela of an accepted worsened condition at the time the worker is likely to become medically stationary;

(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and

(C) Estimate the portion of the loss that is likely to be caused by:

(i) Any accepted worsened condition;

(ii) Any direct medical sequela of an accepted worsened condition;

(iii) Any condition that existed before the onset of the accepted worsened condition but does not qualify as a preexisting condition;

(iv) Any preexisting condition that is not otherwise compensable;

(v) Any denied condition; and

(vi) Any superimposed condition.

(d) In occupational disease claims.

(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted occupational disease or a direct medical sequela of an accepted occupational disease at the time the worker is likely to become medically stationary;

(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and

(C) Estimate the portion of the loss that is likely to be caused by:

(i) Any accepted occupational disease;

(ii) Any direct medical sequela of an accepted occupational disease;

(iii) Any preexisting condition that is not otherwise compensable;

(iv) Any denied condition; and

(v) Any superimposed condition.

(4) **Age and education.** The social-vocational factors of age and education (including SVP) are not apportioned, but are determined as of the date of issuance.

(5) **Irreversible findings of impairment or surgical value.** Workers with an irreversible finding of impairment or surgical value due to the compensable injury receive the full value awarded in these rules for the irreversible finding or surgical value.

Example: Compensable injury: Low back strain with herniated disk at L5-S1 and diskectomy.

Noncompensable condition: pregnancy (mid-term)

The worker is released to regular work. In the closing examination, the physician describes range of motion findings and states that 60% of the range of motion loss is due to the compensable injury. Under these rules, the range of motion loss is valued at 10%. 10% x .60 equals 6%.

Diskectomy at L5-S1 (irreversible finding) = 9% per these rules.

Combine 9% with 6% for a value of 14% impairment for the compensable injury.

Stat. Auth.: ORS 656.726:
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 1/29/15 as WCD Admin. Order 15-053, eff. 3/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0014 Preexisting Conditions and Combined Conditions

(1) **Preexisting conditions, generally.** A worker is not eligible for an award for permanent disability caused by a preexisting condition, unless the preexisting condition is otherwise compensable.

(2) **Worsened preexisting conditions.** If a worsened preexisting condition is compensable under ORS 656.225, a worker is eligible for an award for permanent disability caused by the worsened preexisting condition.

Example: (No apportionment):

Compensable injury (remains major contributing cause): Herniated disk L5-S1/diskectomy.

Preexisting condition: arthritis (spine).

Closing exam ROM = 10% (under these rules).

Surgery (lumbar diskectomy) = 9%

Combine: 10% and 9% which equals 18% low back impairment due to this compensable injury.

The worker is released to regular work. (Social-vocational factoring equals zero.)

(3) **Combined conditions.** If a worker's compensable injury combines with a preexisting condition, under ORS 656.005(7), to cause or prolong disability or a need for treatment, the worker has a combined condition. If a combined condition is compensable, a worker is eligible for an award for permanent disability caused by the combined condition.

(4) **Permanent partial disability awarded after a major contributing cause denial.** If a claim is closed under ORS 656.268(1)(b), because the compensable injury is no longer the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition, the likely permanent disability that would have been due to the current accepted condition must be estimated. The current accepted condition is

the component of the otherwise denied combined condition that remains related to the compensable injury.

Stat. Auth.: ORS 656.726:
Stats. Implemented: ORS 656.005, 656.214, 656.225, 656.268, 656.726
Hist.: Amended 1/29/15 as WCD Admin. Order 15-053, eff. 3/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0015 Offsetting Prior Awards

If a worker has a prior award of permanent disability under Oregon Workers' Compensation Law, the award is considered in subsequent claims under ORS 656.222 and ORS 656.214.

(1) A prior award can be used to offset an award for a subsequent claim when all the following are true:

(a) The prior claim is closed under Oregon Workers' Compensation Law;

(b) The prior claim has an award of permanent disability;

(c) The disability in the prior claim has not fully dissipated as outlined in section (2) of this rule; and

(d) Both claims have similar disabilities as outlined in sections (3) and (4) of this rule.

(2) A disability from a prior claim is considered to have fully dissipated if there is not a preponderance of medical evidence or opinion establishing that disability from the prior injury or disease was still present on the date of the injury or disease of the claim being determined. If disability from the prior injury or disease was not still present, an offset is not applied.

(3) The following are considered when determining what impairment findings can be offset from a prior claim:

(a) Only identical impairment findings of like body parts or systems are to be offset (e.g., left leg sensation loss to left leg sensation loss, chronic low back to chronic low back, psychological to psychological, etc.).

(b) A more distal body part impairment finding may be offset against a more proximal body part impairment finding (or vice versa) if there is a combined effect of impairment (e.g., a right forearm impairment finding may be offset against a right arm impairment finding).

(c) Irreversible findings and surgical values are not offset.

(4) The following are considered when determining what disability findings can be offset from a prior claim:

(a) When a worker successfully returns to work in a position requiring greater physical capacity than the RFC established at the time of claim closure in a prior claim, an offset is not applied. The BFC for the current claim closure is established under OAR 436-035-0012, without offsetting the RFC from the prior claim.

(b) The social-vocational factors of age and education (including SVP) are not offset, but are redetermined as of the date of issuance.

(5) The following are considered when calculating the current disability award and applying an offset:

(a) The worker's loss of use or function or loss of earning capacity for the current disability under the standards;

(b) The conditions or findings of impairment from the prior awards which were still present just prior to the current claim;

(c) The worker's adaptability factors which were still present just prior to the current claim, if appropriate; and

(d) The combined effect of the prior and current injuries (the overall disability to a given body part), including the extent to which the current loss of use or function or loss of earning capacity (impairment and social-vocational factors) from a prior injury or disease was still present at the time of the current injury or disease. After considering and comparing the claims, any award of compensation in the current claim for loss of use or function or loss of earning capacity caused by the current injury or disease (which did not exist at the time of the current injury or disease and for which the worker was not previously compensated) is granted.

(e) When there is measurable impairment in the current claim and the worker has not returned to regular work but the offset applied reduces the impairment award to zero, the worker is entitled to a work disability award. The work disability calculation must include the percentage of measurable impairment from the current claim.

Stat. Auth.: ORS 656.726:
Stats. Implemented: ORS 656.005, 656.214, 656.222, 656.268, 656.726
Hist.: Amended 5/5/10 as WCD Admin. Order 10-051, eff. 6/1/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0016 Reopened Claim for Aggravation/Worsening

(1) **Worsened conditions.** When an aggravation claim is closed, the extent of permanent disability caused by any worsened condition accepted under the aggravation claim is compared to the extent of disability that existed at the time of the last award or arrangement of compensation.

(2) **Conditions not actually worsened.** Permanent disability caused by conditions not actually worsened continues to be the same as that established at the last arrangement of compensation.

(3) **Redetermination of permanent disability.** Except as provided by ORS 656.325 and 656.268(10), where a redetermination of permanent disability under ORS 656.273 results in an award that is less than the total of the worker's prior arrangements of compensation in the claim, the award is not reduced.

Stat. Auth.: ORS 656.726, 656.273:
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
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See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0017 Authorized Training Program (ATP)

(1) When a worker ceases to be enrolled and actively engaged in training under ORS 656.268(10) and there is no accepted aggravation in the current open period, one of the following applies:

(a) When the date of injury is prior to January 1, 2005, the worker is entitled to have the amount of unscheduled permanent disability for a compensable condition reevaluated under these rules. The re-evaluation includes impairment, which may increase, decrease, or affirm the worker's permanent disability award; or

(b) When the date of injury is on or after January 1, 2005, the worker's work disability is re-evaluated under these rules. Impairment is not re-evaluated. The re-evaluation of the work disability may increase, decrease, or affirm the worker's permanent disability award.

(2) When a worker ceases to be enrolled and actively engaged in training under ORS 656.268(10) and there is an accepted aggravation in the same open period, permanent partial disability is redetermined under OAR 436-035-0016.

Stat. Auth.: ORS 656.726:
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0018 Death

(1) **If a closing report has been completed.** If the worker dies due to causes unrelated to the compensable injury and a closing report has been completed, the worker's permanent disability must be determined based on the closing report.

(2) **If a closing report has not been completed.** If the worker dies due to causes unrelated to the compensable injury and a closing report has not been completed, findings of impairment and permanent work restrictions must be estimated.

(a) The estimate must qualify as either a statement of no permanent disability under OAR 436-030-0020(2)(a) or a closing report under OAR 436-030-0020(2)(b).

(b) If the worker was medically stationary at the time of death, the following applies:

(A) Findings of impairment and permanent work restrictions are determined based on an estimate of the permanent disability that existed at the time the worker was medically stationary; and

(B) The worker's residual functional capacity is determined based on an estimate of the worker's ability to perform work-related activities at the time the worker was medically stationary.

(c) If the worker was not medically stationary at the time of death, the following applies:

(A) Findings of impairment and permanent work restrictions are determined based on an estimate of the permanent disability that would have existed at the time the worker would have likely become medically stationary; and

(B) The worker's residual functional capacity is determined based on an estimate of the worker's ability to perform work-related activities at the time the worker would have likely become medically stationary.

(3) In claims where, at the time of death, there is a compensable condition that is medically stationary and a compensable condition that is not medically stationary, the conditions are rated under sections (1) and (2) of this rule, respectively. The adaptability factor is determined by comparing the adaptability values from sections (1) and (2) of this rule, and using the higher of the values for adaptability.

(4) If the worker dies due to causes related to the compensable injury, death benefits are due under ORS 656.204 and 656.208.

Stat. Auth.: ORS 656.726:
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 1/29/15 as WCD Admin. Order 15-053, eff. 3/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0019 Chronic Condition

(1) A worker is entitled to a 5% chronic condition impairment value for each applicable body part, when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of one or more of the following body parts:

(a) Lower leg (below knee/foot/ankle);

(b) Upper leg (knee and above);

(c) Forearm (below elbow/hand/wrist);

(d) Arm (elbow and above);

(e) Cervical;

(f) Thoracic spine;

(g) Shoulder;

(h) Low back;

(i) Hip; or

(j) Chest.

(2) Chronic condition impairments are to be combined with other impairment values, not added.

Stat. Auth.: ORS 656.726:
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 5/5/10 as WCD Admin. Order 10-051, eff. 6/1/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0020 Parts of the Upper Extremities

(1) The arm begins with the head of the humerus. It includes the elbow joint.

(2) The forearm begins distal to the elbow joint and includes the wrist (carpal bones).

(3) The hand begins at the joints between the carpals and metacarpals. It extends to the joints between the metacarpals and the phalanges.

(4) The thumb and fingers begin at the joints between the metacarpal bones and the phalanges. They extend to the tips of the thumb and fingers, respectively.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 10-26-04 as WCD Admin. Order 04-063, eff. 1-1-05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0030 Amputations in the Upper Extremities

(1) Loss of the arm at or proximal to the elbow joint is 100% loss of the arm.

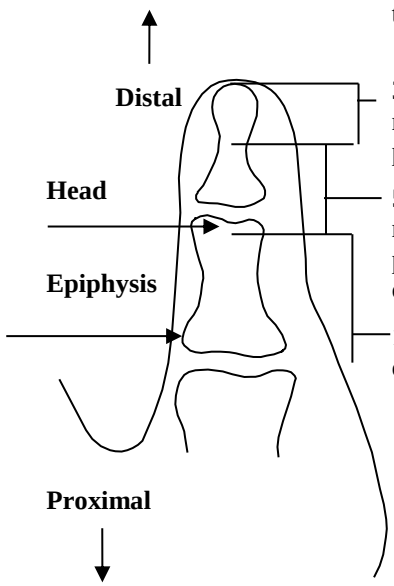
(2) Loss of the forearm at or proximal to the wrist joint is 100% loss of the forearm.

(3) Loss of the hand at the carpal bones is 100% loss of the hand.

(4) Loss of all or part of a metacarpal is rated at 10% of the hand.

(5) Amputation or resection (without reattachment) proximal to the head of the proximal phalanx is 100% loss of the thumb. The ratings for other amputation(s) or resection(s) (without reattachment) of the thumb are as follows:

Thumb



0% = Skin (dermis) only

10% = Significant flesh or tissue loss only (no bone)

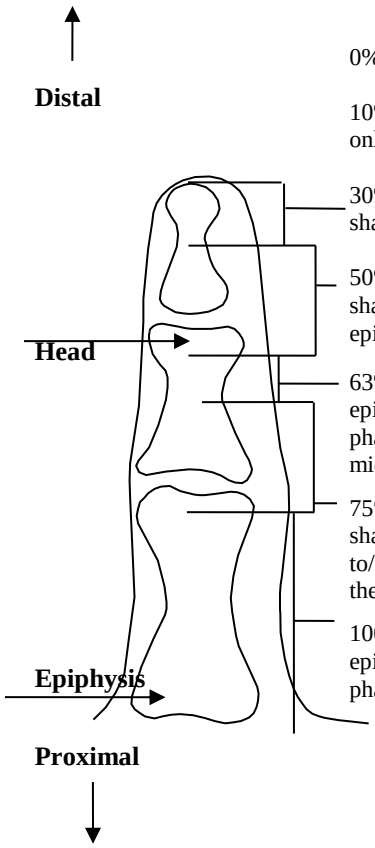
30% = Bone involvement to mid-shaft of the distal phalanx

50% = Proximal to/including mid-shaft of the distal phalanx to/including the head of the proximal phalanx

100% = Proximal to the head of the proximal phalanx

(6) Amputation or resection (without reattachment) proximal to the head of the proximal phalanx is 100% loss of the finger. The ratings for other amputation(s) or resection(s) (without reattachment) of the finger are as follows:

Finger



0% = Skin (dermis) only

10% = Significant flesh or tissue loss only (no bone)

30% = Bone involvement to mid-shaft of distal phalanx

50% = Proximal to/including mid-shaft of distal phalanx to the distal epiphysis of the middle phalanx

63% = Proximal to the distal epiphysis (head) of the middle phalanx to the mid-shaft of the middle phalanx

75% = Proximal to/including mid-shaft of the middle phalanx to/including the distal epiphysis of the proximal phalanx

100% = Proximal to the distal epiphysis (head) of the proximal phalanx

(7) Oblique (angled) amputations are rated at the most proximal loss of bone.

(8) When a value is granted under sections (5) and (6) of this rule which includes a joint, no value for range of motion of this joint is granted in addition to the amputation value.

(9) Loss of length in a digit other than amputation or resection without reattachment (e.g., fractures, loss of soft tissue from infection, amputation or resection with reattachment, etc.) is rated by comparing the remaining overall length of the digit to the applicable amputation chart under these rules and rating the overall length equivalency.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0040 Loss of Opposition in Thumb/Finger Amputations

(1) Loss of opposition is rated as a proportionate loss of use of the digits which can no longer be effectively opposed.

(a) For amputations which are not exactly at the joints, adjust the ratings in steps of 5%, increasing as the amputation gets closer to the attachment to the hand, decreasing to zero as it gets closer to the tip.

(b) When the value for loss of opposition is less than 5%, no value is granted.

(2) The following ratings apply to thumb amputations for loss of opposition:

(a) For thumb amputations at the interphalangeal level:

Opposing digit	Finger
index finger	20%
middle finger	20%
ring finger	10%
little finger	5%

(b) For thumb amputations at the metacarpophalangeal level:

Opposing digit	Finger
index finger	40%
middle finger	40%
ring finger	20%
little finger	10%

(3) The following ratings apply to finger amputations for loss of opposition. In every case, the opposing digit is the thumb:

For finger amputations at the distal interphalangeal joint:

	Thumb
index finger	10%
middle finger	10%
ring finger	5%
little finger	5%

For finger amputations at the proximal interphalangeal joint:

	Thumb
index finger	25%
middle finger	25%
ring finger	10%
little finger	10%

For finger amputations at the metacarpophalangeal joint:

	Thumb
index finger	30%
middle finger	30%
ring finger	20%
little finger	20%

(4) When determining loss of opposition due to loss of length in a digit, other than amputation or resection without reattachment, the value is established by comparing the remaining overall length of the digit to the applicable amputation chart under these rules and rated based on the overall length equivalency.

(5) If the injury is to one digit only and opposition loss is awarded for a second digit, do not convert the two digits to loss in the hand. Conversion to hand can take place only when more than one digit has impairment without considering opposition.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0050 Thumb

(1) The following ratings are for loss of flexion at the interphalangeal joint of the thumb:

Retained Motion/Percentage of Impairment

0° = 45.0%	27° = 29.8%	54° = 14.6%
1° = 44.4%	28° = 29.2%	55° = 14.0%
2° = 43.8%	29° = 28.6%	56° = 13.4%
3° = 43.2%	30° = 28.0%	57° = 12.8%
4° = 42.6%	31° = 27.5%	58° = 12.2%
5° = 42.0%	32° = 27.0%	59° = 11.6%
6° = 41.4%	33° = 26.5%	60° = 11.0%
7° = 40.8%	34° = 26.0%	61° = 10.5%
8° = 40.2%	35° = 25.5%	62° = 10.0%
9° = 39.6%	36° = 25.0%	63° = 9.5%
10° = 39.0%	37° = 24.5%	64° = 9.0%
11° = 38.5%	38° = 24.0%	65° = 8.5%
12° = 38.0%	39° = 23.5%	66° = 8.0%
13° = 37.5%	40° = 23.0%	67° = 7.5%
14° = 37.0%	41° = 22.4%	68° = 7.0%
15° = 36.5%	42° = 21.8%	69° = 6.5%
16° = 36.0%	43° = 21.2%	70° = 6.0%
17° = 35.5%	44° = 20.6%	71° = 5.4%
18° = 35.0%	45° = 20.0%	72° = 4.8%
19° = 34.5%	46° = 19.4%	73° = 4.2%
20° = 34.0%	47° = 18.8%	74° = 3.6%
21° = 33.4%	48° = 18.2%	75° = 3.0%
22° = 32.8%	49° = 17.6%	76° = 2.4%
23° = 32.2%	50° = 17.0%	77° = 1.8%
24° = 31.6%	51° = 16.4%	78° = 1.2%
25° = 31.0%	52° = 15.8%	79° = 0.6%
26° = 30.4%	53° = 15.2%	80° = 0.0%

(2) The following ratings are for loss of extension at the interphalangeal joint of the thumb:

Retained Motion/Percentage of Impairment

0° = 0.0%	27° = 8.8%	54° = 24.2%
1° = 0.4%	28° = 9.2%	55° = 25.0%
2° = 0.8%	29° = 9.6%	56° = 25.8%
3° = 1.2%	30° = 10.0%	57° = 26.6%
4° = 1.6%	31° = 10.2%	58° = 27.4%
5° = 2.0%	32° = 10.4%	59° = 28.2%
6° = 2.4%	33° = 10.6%	60° = 29.0%
7° = 2.8%	34° = 10.8%	61° = 29.8%
8° = 3.2%	35° = 11.0%	62° = 30.6%
9° = 3.6%	36° = 11.2%	63° = 31.4%
10° = 4.0%	37° = 11.4%	64° = 32.2%
11° = 4.2%	38° = 11.6%	65° = 33.0%
12° = 4.4%	39° = 11.8%	66° = 33.8%
13° = 4.6%	40° = 12.0%	67° = 34.6%
14° = 4.8%	41° = 12.9%	68° = 35.4%
15° = 5.0%	42° = 13.8%	69° = 36.2%
16° = 5.2%	43° = 14.7%	70° = 37.0%
17° = 5.4%	44° = 15.6%	71° = 37.8%
18° = 5.6%	45° = 16.5%	72° = 38.6%
19° = 5.8%	46° = 17.4%	73° = 39.4%
20° = 6.0%	47° = 18.3%	74° = 40.2%
21° = 6.4%	48° = 19.2%	75° = 41.0%
22° = 6.8%	49° = 20.1%	76° = 41.8%
23° = 7.2%	50° = 21.0%	77° = 42.6%
24° = 7.6%	51° = 21.8%	78° = 43.4%
25° = 8.0%	52° = 22.6%	79° = 44.2%
26° = 8.4%	53° = 23.4%	80° = 45.0%

(3) The following ratings are for ankylosis of the interphalangeal joint of the thumb:

Joint Ankylosed at/Percentage of Impairment

0° = 45.0%	27° = 38.6%	54° = 38.8%
1° = 44.8%	28° = 38.4%	55° = 39.0%
2° = 44.6%	29° = 38.2%	56° = 39.2%
3° = 44.4%	30° = 38.0%	57° = 39.4%
4° = 44.2%	31° = 37.7%	58° = 39.6%
5° = 44.0%	32° = 37.4%	59° = 39.8%
6° = 43.8%	33° = 37.1%	60° = 40.0%
7° = 43.6%	34° = 36.8%	61° = 40.3%
8° = 43.4%	35° = 36.5%	62° = 40.6%
9° = 43.2%	36° = 36.2%	63° = 40.9%
10° = 43.0%	37° = 35.9%	64° = 41.2%
11° = 42.7%	38° = 35.6%	65° = 41.5%
12° = 42.4%	39° = 35.3%	66° = 41.8%
13° = 42.1%	40° = 35.0%	67° = 42.1%
14° = 41.8%	41° = 35.3%	68° = 42.4%
15° = 41.5%	42° = 35.6%	69° = 42.7%
16° = 41.2%	43° = 35.9%	70° = 43.0%
17° = 40.9%	44° = 36.2%	71° = 43.2%
18° = 40.6%	45° = 36.5%	72° = 43.4%
19° = 40.3%	46° = 36.8%	73° = 43.6%
20° = 40.0%	47° = 37.1%	74° = 43.8%
21° = 39.8%	48° = 37.4%	75° = 44.0%
22° = 39.6%	49° = 37.7%	76° = 44.2%
23° = 39.4%	50° = 38.0%	77° = 44.4%
24° = 39.2%	51° = 38.2%	78° = 44.6%
25° = 39.0%	52° = 38.4%	79° = 44.8%
26° = 38.8%	53° = 38.6%	80° = 45.0%

(4) The following ratings are for loss of flexion at the metacarpophalangeal joint of the thumb:

Retained Motion/Percentage of Impairment

0° = 55.0%	21° = 36.0%	41° = 17.1%
1° = 54.1%	22° = 35.0%	42° = 16.2%
2° = 53.2%	23° = 34.0%	43° = 15.3%
3° = 52.3%	24° = 33.0%	44° = 14.4%
4° = 51.4%	25° = 32.0%	45° = 13.5%
5° = 50.5%	26° = 31.0%	46° = 12.6%
6° = 49.6%	27° = 30.0%	47° = 11.7%
7° = 48.7%	28° = 29.0%	48° = 10.8%
8° = 47.8%	29° = 28.0%	49° = 9.9%
9° = 46.9%	30° = 27.0%	50° = 9.0%
10° = 46.0%	31° = 26.1%	51° = 8.1%
11° = 45.1%	32° = 25.2%	52° = 7.2%
12° = 44.2%	33° = 24.3%	53° = 6.3%
13° = 43.3%	34° = 23.4%	54° = 5.4%
14° = 42.4%	35° = 22.5%	55° = 4.5%
15° = 41.5%	36° = 21.6%	56° = 3.6%
16° = 40.6%	37° = 20.7%	57° = 2.7%
17° = 39.7%	38° = 19.8%	58° = 1.8%
18° = 38.8%	39° = 18.9%	59° = 0.9%
19° = 37.9%	40° = 18.0%	60° = 0.0%
20° = 37.0%		

(5) The following ratings are for loss of extension at the metacarpophalangeal joint of the thumb:

Retained Motion/Percentage of Impairment

0° = 0.0%	21° = 7.9%	41° = 44.8%
1° = 0.3%	22° = 9.8%	42° = 46.6%
2° = 0.6%	23° = 11.7%	43° = 48.4%
3° = 0.9%	24° = 13.6%	44° = 50.2%
4° = 1.2%	25° = 15.5%	45° = 52.0%
5° = 1.5%	26° = 17.4%	46° = 53.8%
6° = 1.8%	27° = 19.3%	47° = 55.6%
7° = 2.1%	28° = 21.2%	48° = 57.4%
8° = 2.4%	29° = 23.1%	49° = 59.2%
9° = 2.7%	30° = 25.0%	50° = 61.0%
10° = 3.0%	31° = 26.8%	51° = 62.9%
11° = 3.3%	32° = 28.6%	52° = 64.8%
12° = 3.6%	33° = 30.4%	53° = 66.7%
13° = 3.9%	34° = 32.2%	54° = 68.6%
14° = 4.2%	35° = 34.0%	55° = 70.5%
15° = 4.5%	36° = 35.8%	56° = 72.4%
16° = 4.8%	37° = 37.6%	57° = 74.3%
17° = 5.1%	38° = 39.4%	58° = 76.2%
18° = 5.4%	39° = 41.2%	59° = 78.1%
19° = 5.7%	40° = 43.0%	60° = 80.0%
20° = 6.0%		

(6) The following ratings are for ankylosis of the metacarpophalangeal joint of the thumb:

Joint Ankylosed at/Percentage of Impairment

0° = 55.0%	21° = 43.9%	41° = 61.9%
1° = 54.4%	22° = 44.8%	42° = 62.8%
2° = 53.8%	23° = 45.7%	43° = 63.7%
3° = 53.2%	24° = 46.6%	44° = 64.6%
4° = 52.6%	25° = 47.5%	45° = 65.5%
5° = 52.0%	26° = 48.4%	46° = 66.4%
6° = 51.4%	27° = 49.3%	47° = 67.3%
7° = 50.8%	28° = 50.2%	48° = 68.2%
8° = 50.2%	29° = 51.1%	49° = 69.1%
9° = 49.6%	30° = 52.0%	50° = 70.0%
10° = 49.0%	31° = 52.9%	51° = 71.0%
11° = 48.4%	32° = 53.8%	52° = 72.0%
12° = 47.8%	33° = 54.7%	53° = 73.0%
13° = 47.2%	34° = 55.6%	54° = 74.0%
14° = 46.6%	35° = 56.5%	55° = 75.0%
15° = 46.0%	36° = 57.4%	56° = 76.0%
16° = 45.4%	37° = 58.3%	57° = 77.0%
17° = 44.8%	38° = 59.2%	58° = 78.0%
18° = 44.2%	39° = 60.1%	59° = 79.0%
19° = 43.6%	40° = 61.0%	60° = 80.0%
20° = 43.0%		

(7) For losses in the carpometacarpal joint refer to OAR 436-035-0075.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 5/5/10 as WCD Admin. Order 10-051, eff. 6/1/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0060 Finger

(1) The following ratings are for loss of flexion at the distal interphalangeal joint of any finger:

Retained Motion/Percentage of Impairment

0° = 45.0%	23° = 30.2%	47° = 14.8%
1° = 44.3%	24° = 29.6%	48° = 14.2%
2° = 43.6%	25° = 29.0%	49° = 13.6%
3° = 42.9%	26° = 28.4%	50° = 13.0%
4° = 42.2%	27° = 27.8%	51° = 12.3%
5° = 41.5%	28° = 27.2%	52° = 11.6%
6° = 40.8%	29° = 26.6%	53° = 10.9%
7° = 40.1%	30° = 26.0%	54° = 10.2%
8° = 39.4%	31° = 25.3%	55° = 9.5%
9° = 38.7%	32° = 24.6%	56° = 8.8%
10° = 38.0%	33° = 23.9%	57° = 8.1%
11° = 37.4%	34° = 23.2%	58° = 7.4%
12° = 36.8%	35° = 22.5%	59° = 6.7%
13° = 36.2%	36° = 21.8%	60° = 6.0%
14° = 35.6%	37° = 21.1%	61° = 5.4%
15° = 35.0%	38° = 20.4%	62° = 4.8%
16° = 34.4%	39° = 19.7%	63° = 4.2%
17° = 33.8%	40° = 19.0%	64° = 3.6%
18° = 33.2%	41° = 18.4%	65° = 3.0%
19° = 32.6%	42° = 17.8%	66° = 2.4%
20° = 32.0%	43° = 17.2%	67° = 1.8%
21° = 31.4%	44° = 16.6%	68° = 1.2%
22° = 30.8%	45° = 16.0%	69° = 0.6%
	46° = 15.4%	70° = 0.0%

(2) The following ratings are for loss of extension at the distal interphalangeal joint of any finger:

Retained Motion/Percentage of Impairment

0° = 0.0%	23° = 6.6%	47° = 18.7%
1° = 0.3%	24° = 6.8%	48° = 19.8%
2° = 0.6%	25° = 7.0%	49° = 20.9%
3° = 0.9%	26° = 7.2%	50° = 22.0%
4° = 1.2%	27° = 7.4%	51° = 23.2%
5° = 1.5%	28° = 7.6%	52° = 24.4%
6° = 1.8%	29° = 7.8%	53° = 25.6%
7° = 2.1%	30° = 8.0%	54° = 26.8%
8° = 2.4%	31° = 8.3%	55° = 28.0%
9° = 2.7%	32° = 8.6%	56° = 29.2%
10° = 3.0%	33° = 8.9%	57° = 30.4%
11° = 3.3%	34° = 9.2%	58° = 31.6%
12° = 3.6%	35° = 9.5%	59° = 32.8%
13° = 3.9%	36° = 9.8%	60° = 34.0%
14° = 4.2%	37° = 10.1%	61° = 35.1%
15° = 4.5%	38° = 10.4%	62° = 36.2%
16° = 4.8%	39° = 10.7%	63° = 37.3%
17° = 5.1%	40° = 11.0%	64° = 38.4%
18° = 5.4%	41° = 12.1%	65° = 39.5%
19° = 5.7%	42° = 13.2%	66° = 40.6%
20° = 6.0%	43° = 14.3%	67° = 41.7%
21° = 6.2%	44° = 15.4%	68° = 42.8%

22° = 6.4%	45° = 16.5%	69° = 43.9%
	46° = 17.6%	70° = 45.0%

(3) The following ratings are for ankylosis in the distal interphalangeal joint of any finger:

Joint Ankylosed at/Percentage of Impairment

0° = 45.0%	23° = 36.8%	47° = 33.5%
1° = 44.6%	24° = 36.4%	48° = 34.0%
2° = 44.2%	25° = 36.0%	49° = 34.5%
3° = 43.8%	26° = 35.6%	50° = 35.0%
4° = 43.4%	27° = 35.2%	51° = 35.5%
5° = 43.0%	28° = 34.8%	52° = 36.0%
6° = 42.6%	29° = 34.4%	53° = 36.5%
7° = 42.2%	30° = 34.0%	54° = 37.0%
8° = 41.8%	31° = 33.6%	55° = 37.5%
9° = 41.4%	32° = 33.2%	56° = 38.0%
10° = 41.0%	33° = 32.8%	57° = 38.5%
11° = 40.7%	34° = 32.4%	58° = 39.0%
12° = 40.4%	35° = 32.0%	59° = 39.5%
13° = 40.1%	36° = 31.6%	60° = 40.0%
14° = 39.8%	37° = 31.2%	61° = 40.5%
15° = 39.5%	38° = 30.8%	62° = 41.0%
16° = 39.2%	39° = 30.4%	63° = 41.5%
17° = 38.9%	40° = 30.0%	64° = 42.0%
18° = 38.6%	41° = 30.5%	65° = 42.5%
19° = 38.3%	42° = 31.0%	66° = 43.0%
20° = 38.0%	43° = 31.5%	67° = 43.5%
21° = 37.6%	44° = 32.0%	68° = 44.0%
22° = 37.2%	45° = 32.5%	69° = 44.5%
	46° = 33.0%	70° = 45.0%

(4) The following ratings are for loss of flexion at the proximal interphalangeal joint of any finger:

Retained Motion/Percentage of Impairment

0° = 60.0%	34° = 39.6%	68° = 19.2%
1° = 59.4%	35° = 39.0%	69° = 18.6%
2° = 58.8%	36° = 38.4%	70° = 18.0%
3° = 58.2%	37° = 37.8%	71° = 17.4%
4° = 57.6%	38° = 37.2%	72° = 16.8%
5° = 57.0%	39° = 36.6%	73° = 16.2%
6° = 56.4%	40° = 36.0%	74° = 15.6%
7° = 55.8%	41° = 35.4%	75° = 15.0%
8° = 55.2%	42° = 34.8%	76° = 14.4%
9° = 54.6%	43° = 34.2%	77° = 13.8%
10° = 54.0%	44° = 33.6%	78° = 13.2%
11° = 53.4%	45° = 33.0%	79° = 12.6%
12° = 52.8%	46° = 32.4%	80° = 12.0%
13° = 52.2%	47° = 31.8%	81° = 11.4%
14° = 51.6%	48° = 31.2%	82° = 10.8%
15° = 51.0%	49° = 30.6%	83° = 10.2%
16° = 50.4%	50° = 30.0%	84° = 9.6%
17° = 49.8%	51° = 29.4%	85° = 9.0%
18° = 49.2%	52° = 28.8%	86° = 8.4%
19° = 48.6%	53° = 28.2%	87° = 7.8%
20° = 48.0%	54° = 27.6%	88° = 7.2%
21° = 47.4%	55° = 27.0%	89° = 6.6%
22° = 46.8%	56° = 26.4%	90° = 6.0%
23° = 46.2%	57° = 25.8%	91° = 5.4%
24° = 45.6%	58° = 25.2%	92° = 4.8%
25° = 45.0%	59° = 24.6%	93° = 4.2%
26° = 44.4%	60° = 24.0%	94° = 3.6%
27° = 43.8%	61° = 23.4%	95° = 3.0%
28° = 43.2%	62° = 22.8%	96° = 2.4%
29° = 42.6%	63° = 22.2%	97° = 1.8%
30° = 42.0%	64° = 21.6%	98° = 1.2%
31° = 41.4%	65° = 21.0%	99° = 0.6%
32° = 40.8%	66° = 20.4%	100° = 0.0%
33° = 40.2%	67° = 19.8%	

(5) The following ratings are for loss of extension at the proximal interphalangeal joint of any finger:

Retained Motion/Percentage of Impairment

0° = 0.0%	34° = 12.2%	68° = 40.2%
1° = 0.3%	35° = 12.5%	69° = 41.1%
2° = 0.6%	36° = 12.8%	70° = 42.0%
3° = 0.9%	37° = 13.1%	71° = 42.9%
4° = 1.2%	38° = 13.4%	72° = 43.8%
5° = 1.5%	39° = 13.7%	73° = 44.7%
6° = 1.8%	40° = 14.0%	74° = 45.6%
7° = 2.1%	41° = 14.9%	75° = 46.5%
8° = 2.4%	42° = 15.8%	76° = 47.4%
9° = 2.7%	43° = 16.7%	77° = 48.3%
10° = 3.0%	44° = 17.6%	78° = 49.2%
11° = 3.4%	45° = 18.5%	79° = 50.1%
12° = 3.8%	46° = 19.4%	80° = 51.0%
13° = 4.2%	47° = 20.3%	81° = 52.0%
14° = 4.6%	48° = 21.2%	82° = 53.0%
15° = 5.0%	49° = 22.1%	83° = 54.0%
16° = 5.4%	50° = 23.0%	84° = 55.0%
17° = 5.8%	51° = 24.0%	85° = 56.0%
18° = 6.2%	52° = 25.0%	86° = 57.0%
19° = 6.6%	53° = 26.0%	87° = 58.0%
20° = 7.0%	54° = 27.0%	88° = 59.0%
21° = 7.4%	55° = 28.0%	89° = 60.0%
22° = 7.8%	56° = 29.0%	90° = 61.0%
23° = 8.2%	57° = 30.0%	91° = 61.9%
24° = 8.6%	58° = 31.0%	92° = 62.8%
25° = 9.0%	59° = 32.0%	93° = 63.7%
26° = 9.4%	60° = 33.0%	94° = 64.6%
27° = 9.8%	61° = 33.9%	95° = 65.5%
28° = 10.2%	62° = 34.8%	96° = 66.4%
29° = 10.6%	63° = 35.7%	97° = 67.3%
30° = 11.0%	64° = 36.6%	98° = 68.2%
31° = 11.3%	65° = 37.5%	99° = 69.1%
32° = 11.6%	66° = 38.4%	100° = 70.0%
33° = 11.9%	67° = 39.3%	

(6) The following ratings are for ankylosis in the proximal interphalangeal joint of any finger:

Joint Ankylosed at/Percentage of Impairment

0° = 60.0%	34° = 51.8%	68° = 59.4%
1° = 59.7%	35° = 51.5%	69° = 59.7%
2° = 59.4%	36° = 51.2%	70° = 60.0%
3° = 59.1%	37° = 50.9%	71° = 60.3%
4° = 58.8%	38° = 50.6%	72° = 60.6%
5° = 58.5%	39° = 50.3%	73° = 60.9%
6° = 58.2%	40° = 50.0%	74° = 61.2%
7° = 57.9%	41° = 50.3%	75° = 61.5%
8° = 57.6%	42° = 50.6%	76° = 61.8%
9° = 57.3%	43° = 50.9%	77° = 62.1%
10° = 57.0%	44° = 51.2%	78° = 62.4%
11° = 56.8%	45° = 51.5%	79° = 62.7%
12° = 56.6%	46° = 51.8%	80° = 63.0%
13° = 56.4%	47° = 52.1%	81° = 63.4%
14° = 56.2%	48° = 52.4%	82° = 63.8%
15° = 56.0%	49° = 52.7%	83° = 64.2%
16° = 55.8%	50° = 53.0%	84° = 64.6%
17° = 55.6%	51° = 53.4%	85° = 65.0%
18° = 55.4%	52° = 53.8%	86° = 65.4%
19° = 55.2%	53° = 54.2%	87° = 65.8%
20° = 55.0%	54° = 54.6%	88° = 66.2%
21° = 54.8%	55° = 55.0%	89° = 66.6%
22° = 54.6%	56° = 55.4%	90° = 67.0%
23° = 54.4%	57° = 55.8%	91° = 67.3%
24° = 54.2%	58° = 56.2%	92° = 67.6%
25° = 54.0%	59° = 56.6%	93° = 67.9%
26° = 53.8%	60° = 57.0%	94° = 68.2%
27° = 53.6%	61° = 57.3%	95° = 68.5%
28° = 53.4%	62° = 57.6%	96° = 68.8%
29° = 53.2%	63° = 57.9%	97° = 69.1%
30° = 53.0%	64° = 58.2%	98° = 69.4%
31° = 52.7%	65° = 58.5%	99° = 69.7%
32° = 52.4%	66° = 58.8%	100° = 70.0%
33° = 52.1%	67° = 59.1%	

(7) The following ratings are for loss of flexion at the metacarpophalangeal joint of any finger:

Retained Motion/Percentage of Impairment

0° = 55.0%	30° = 37.0%	60° = 18.0%
1° = 54.4%	31° = 36.4%	61° = 17.4%
2° = 53.8%	32° = 35.8%	62° = 16.8%
3° = 53.2%	33° = 35.2%	63° = 16.2%
4° = 52.6%	34° = 34.6%	64° = 15.6%
5° = 52.0%	35° = 34.0%	65° = 15.0%
6° = 51.4%	36° = 33.4%	66° = 14.4%
7° = 50.8%	37° = 32.8%	67° = 13.8%
8° = 50.2%	38° = 32.2%	68° = 13.2%
9° = 49.6%	39° = 31.6%	69° = 12.6%
10° = 49.0%	40° = 31.0%	70° = 12.0%
11° = 48.4%	41° = 30.3%	71° = 11.4%
12° = 47.8%	42° = 29.6%	72° = 10.8%
13° = 47.2%	43° = 28.9%	73° = 10.2%
14° = 46.6%	44° = 28.2%	74° = 9.6%
15° = 46.0%	45° = 27.5%	75° = 9.0%
16° = 45.4%	46° = 26.8%	76° = 8.4%
17° = 44.8%	47° = 26.1%	77° = 7.8%
18° = 44.2%	48° = 25.4%	78° = 7.2%
19° = 43.6%	49° = 24.7%	79° = 6.6%
20° = 43.0%	50° = 24.0%	80° = 6.0%
21° = 42.4%	51° = 23.4%	81° = 5.4%
22° = 41.8%	52° = 22.8%	82° = 4.8%
23° = 41.2%	53° = 22.2%	83° = 4.2%
24° = 40.6%	54° = 21.6%	84° = 3.6%
25° = 40.0%	55° = 21.0%	85° = 3.0%
26° = 39.4%	56° = 20.4%	86° = 2.4%
27° = 38.8%	57° = 19.8%	87° = 1.8%
28° = 38.2%	58° = 19.2%	88° = 1.2%
29° = 37.6%	59° = 18.6%	89° = 0.6%
		90° = 0.0%

(8) The following ratings are for loss of extension at the metacarpophalangeal joint of any finger:

Retained Motion/Percentage of Impairment

0° = 0.0%	30° = 8.0%	60° = 54.0%
1° = 0.3%	31° = 9.5%	61° = 55.6%
2° = 0.6%	32° = 11.0%	62° = 57.2%
3° = 0.9%	33° = 12.5%	63° = 58.8%
4° = 1.2%	34° = 14.0%	64° = 60.4%
5° = 1.5%	35° = 15.5%	65° = 62.0%
6° = 1.8%	36° = 17.0%	66° = 63.6%
7° = 2.1%	37° = 18.5%	67° = 65.2%
8° = 2.4%	38° = 20.0%	68° = 66.8%
9° = 2.7%	39° = 21.5%	69° = 68.4%
10° = 3.0%	40° = 23.0%	70° = 70.0%
11° = 3.2%	41° = 24.6%	71° = 71.5%
12° = 3.4%	42° = 26.2%	72° = 73.0%
13° = 3.6%	43° = 27.8%	73° = 74.5%
14° = 3.8%	44° = 29.4%	74° = 76.0%
15° = 4.0%	45° = 31.0%	75° = 77.5%
16° = 4.2%	46° = 32.6%	76° = 79.0%
17° = 4.4%	47° = 34.2%	77° = 80.5%
18° = 4.6%	48° = 35.8%	78° = 82.0%
19° = 4.8%	49° = 37.4%	79° = 83.5%
20° = 5.0%	50° = 39.0%	80° = 85.0%
21° = 5.3%	51° = 40.5%	81° = 86.5%
22° = 5.6%	52° = 42.0%	82° = 88.0%
23° = 5.9%	53° = 43.5%	83° = 89.5%
24° = 6.2%	54° = 45.0%	84° = 91.0%
25° = 6.5%	55° = 46.5%	85° = 92.5%
26° = 6.8%	56° = 48.0%	86° = 94.0%
27° = 7.1%	57° = 49.5%	87° = 95.5%
28° = 7.4%	58° = 51.0%	88° = 97.0%
29° = 7.7%	59° = 52.5%	89° = 98.5%
		90° = 100.0%

(9) The following ratings are for ankylosis in the metacarpophalangeal joint of any finger:

Joint Ankylosed at/Percentage of Impairment

0° = 55.0%	30° = 45.0%	60° = 72.0%
1° = 54.7%	31° = 45.9%	61° = 73.0%
2° = 54.4%	32° = 46.8%	62° = 74.0%
3° = 54.1%	33° = 47.7%	63° = 75.0%
4° = 53.8%	34° = 48.6%	64° = 76.0%
5° = 53.5%	35° = 49.5%	65° = 77.0%
6° = 53.2%	36° = 50.4%	66° = 78.0%
7° = 52.9%	37° = 51.3%	67° = 79.0%
8° = 52.6%	38° = 52.2%	68° = 80.0%
9° = 52.3%	39° = 53.1%	69° = 81.0%
10° = 52.0%	40° = 54.0%	70° = 82.0%
11° = 51.6%	41° = 54.9%	71° = 82.9%
12° = 51.2%	42° = 55.8%	72° = 83.8%
13° = 50.8%	43° = 56.7%	73° = 84.7%
14° = 50.4%	44° = 57.6%	74° = 85.6%
15° = 50.0%	45° = 58.5%	75° = 86.5%
16° = 49.6%	46° = 59.4%	76° = 87.4%
17° = 49.2%	47° = 60.3%	77° = 88.3%
18° = 48.8%	48° = 61.2%	78° = 89.2%
19° = 48.4%	49° = 62.1%	79° = 90.1%
20° = 48.0%	50° = 63.0%	80° = 91.0%
21° = 47.7%	51° = 63.9%	81° = 91.9%
22° = 47.4%	52° = 64.8%	82° = 92.8%
23° = 47.1%	53° = 65.7%	83° = 93.7%
24° = 46.8%	54° = 66.6%	84° = 94.6%
25° = 46.5%	55° = 67.5%	85° = 95.5%
26° = 46.2%	56° = 68.4%	86° = 96.4%
27° = 45.9%	57° = 69.3%	87° = 97.3%
28° = 45.6%	58° = 70.2%	88° = 98.2%
29° = 45.3%	59° = 71.1%	89° = 99.1%
		90° = 100.0%

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 5/5/10 as WCD Admin. Order 10-051, eff. 6/1/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0070 Conversion of Thumb/Finger Values to Hand Value

(1) Loss of use of two or more digits is converted to a value for loss in the hand if the worker will receive more money for the conversion. At least two digits must have impairment other than loss of opposition to qualify for conversion to hand.

(2) When converting impairment values of digits to hand values, the applicable hand impairment is determined by rating the total impairment value in each digit under OAR 436-035-0011(2)(b), then converting the digit values to hand values, and then adding the converted values. Digit values between zero and one are rounded to one prior to conversion.

(3) The following table is used to convert loss in the thumb to loss in the hand:

Impairment of Thumb Hand	Impairment of Thumb Hand
1- 3% = 1%	51-53% = 17%
4- 6% = 2%	54-56% = 18%
7- 9% = 3%	57-59% = 19%
10-12% = 4%	60-62% = 20%
13-15% = 5%	63-65% = 21%
16-18% = 6%	66-68% = 22%
19-21% = 7%	69-71% = 23%
22-25% = 8%	72-75% = 24%
26-28% = 9%	76-78% = 25%
29-31% = 10%	79-81% = 26%
32-34% = 11%	82-84% = 27%
35-37% = 12%	85-87% = 28%
38-40% = 13%	88-90% = 29%
41-43% = 14%	91-93% = 30%
44-46% = 15%	94-96% = 31%
47-50% = 16%	97-100% = 32%

(4) The following table is used to convert loss in the index finger to loss in the hand:

Impairment of Index Hand	Impairment of Index Hand
1- 6% = 1%	51-56% = 9%
7-12% = 2%	57-62% = 10%
13-18% = 3%	63-68% = 11%
19-25% = 4%	69-75% = 12%
26-31% = 5%	76-81% = 13%
32-37% = 6%	82-87% = 14%
38-43% = 7%	88-93% = 15%
44-50% = 8%	94-100% = 16%

(5) The following table is used to convert loss in the middle finger to loss in the hand:

Impairment of Middle Hand	Impairment of Middle Hand
1- 6% = 1%	55-61% = 9%
7-13% = 2%	62-68% = 10%
14-20% = 3%	69-75% = 11%
21-27% = 4%	76-81% = 12%
28-34% = 5%	82-88% = 13%
35-40% = 6%	89-95% = 14%
41-47% = 7%	96-100% = 15%
48-54% = 8%	

(6) The following table is used to convert loss in the ring finger to loss in the hand:

Impairment of Ring Hand
1- 15% = 1%
16-30% = 2%
31-45% = 3%
46-59% = 4%
60-74% = 5%
75-89% = 6%
90-100% = 7%

(7) The following table is used to convert loss in the little finger to loss in the hand:

Impairment of Little Hand
1-25% = 1%
26-50% = 2%
51-75% = 3%
76-100% = 4%

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 10-26-04 as WCD Admin. Order 04-063, eff 1-1-05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0075 Hand

(1) Under OAR 436-035-0020(3), the ratings in this section are hand values. Abduction and adduction of the carpometacarpal joint of the thumb are associated with the ability to extend and flex. This association has been taken into consideration in establishing the percentages of impairment.

(2) The following ratings are for loss of flexion (adduction) of the carpometacarpal joint of the thumb:

Retained Motion/Percentage of Impairment

0° = 6.0%	5° = 4.0%	10° = 2.0%
1° = 5.6%	6° = 3.6%	11° = 1.6%
2° = 5.2%	7° = 3.2%	12° = 1.2%
3° = 4.8%	8° = 2.8%	13° = 0.8%
4° = 4.4%	9° = 2.4%	14° = 0.4%
		15° = 0.0%

(3) The following ratings are for loss of extension (abduction) of the carpometacarpal joint of the thumb:

Retained Motion/Percentage of Impairment

0° = 6.0%	10° = 4.0%	20° = 2.0%
1° = 5.8%	11° = 3.8%	21° = 1.8%
2° = 5.6%	12° = 3.6%	22° = 1.6%
3° = 5.4%	13° = 3.4%	23° = 1.4%
4° = 5.2%	14° = 3.2%	24° = 1.2%
5° = 5.0%	15° = 3.0%	25° = 1.0%
6° = 4.8%	16° = 2.8%	26° = 0.8%
7° = 4.6%	17° = 2.6%	27° = 0.6%
8° = 4.4%	18° = 2.4%	28° = 0.4%
9° = 4.2%	19° = 2.2%	29° = 0.2%
		30° = 0.0%

(4) The following ratings are for ankylosis of the carpometacarpal joint in flexion (adduction) of the thumb:

Joint Ankylosed at/Percentage of Impairment

0° = 12%	8° = 20%
1° = 13%	9° = 21%
2° = 14%	10° = 22%
3° = 15%	11° = 24%
4° = 16%	12° = 26%
5° = 17%	13° = 28%
6° = 18%	14° = 30%
7° = 19%	15° = 32%

(5) The following ratings are for ankylosis of the carpometacarpal joint in extension (abduction) of the thumb:

Joint Ankylosed at/Percentage of Impairment

0° = 12.0%	10° = 19.0%	20° = 25.0%
1° = 12.7%	11° = 19.6%	21° = 25.7%
2° = 13.4%	12° = 20.2%	22° = 26.4%
3° = 14.1%	13° = 20.8%	23° = 27.1%
4° = 14.8%	14° = 21.4%	24° = 27.8%
5° = 15.5%	15° = 22.0%	25° = 28.5%
6° = 16.2%	16° = 22.6%	26° = 29.2%
7° = 16.9%	17° = 23.2%	27° = 29.9%
8° = 17.6%	18° = 23.8%	28° = 30.6%
9° = 18.3%	19° = 24.4%	29° = 31.3%
		30° = 32.0%

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: Amended 10-26-04 as WCD Admin. Order 04-063, eff 1-1-05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0080 Wrist

(1) The following ratings are for loss of (dorsiflexion) extension at the wrist joint:

Retained Motion/Percentage of Impairment

0° = 10.0%	20° = 6.0%	40° = 3.0%
1° = 9.8%	21° = 5.9%	41° = 2.9%
2° = 9.6%	22° = 5.8%	42° = 2.8%
3° = 9.4%	23° = 5.7%	43° = 2.7%
4° = 9.2%	24° = 5.6%	44° = 2.6%
5° = 9.0%	25° = 5.5%	45° = 2.5%
6° = 8.8%	26° = 5.4%	46° = 2.4%
7° = 8.6%	27° = 5.3%	47° = 2.3%
8° = 8.4%	28° = 5.2%	48° = 2.2%
9° = 8.2%	29° = 5.1%	49° = 2.1%
10° = 8.0%	30° = 5.0%	50° = 2.0%
11° = 7.8%	31° = 4.8%	51° = 1.8%
12° = 7.6%	32° = 4.6%	52° = 1.6%

13° = 7.4%	33° = 4.4%	53° = 1.4%
14° = 7.2%	34° = 4.2%	54° = 1.2%
15° = 7.0%	35° = 4.0%	55° = 1.0%
16° = 6.8%	36° = 3.8%	56° = 0.8%
17° = 6.6%	37° = 3.6%	57° = 0.6%
18° = 6.4%	38° = 3.4%	58° = 0.4%
19° = 6.2%	39° = 3.2%	59° = 0.2%
		60° = 0.0%

(2) The following ratings are for (dorsiflexion) extension ankylosis in the wrist joint:

Joint Ankylosed at/Percentage of Impairment

0° = 30.0%	20° = 27.0%	40° = 47.0%
1° = 29.8%	21° = 26.8%	41° = 49.1%
2° = 29.6%	22° = 26.6%	42° = 51.2%
3° = 29.4%	23° = 26.4%	43° = 53.3%
4° = 29.2%	24° = 26.2%	44° = 55.4%
5° = 29.0%	25° = 26.0%	45° = 57.5%
6° = 28.8%	26° = 25.8%	46° = 59.6%
7° = 28.6%	27° = 25.6%	47° = 61.7%
8° = 28.4%	28° = 25.4%	48° = 63.8%
9° = 28.2%	29° = 25.2%	49° = 65.9%
10° = 28.0%	30° = 25.0%	50° = 68.0%
11° = 27.9%	31° = 27.2%	51° = 70.2%
12° = 27.8%	32° = 29.4%	52° = 72.4%
13° = 27.7%	33° = 31.6%	53° = 74.6%
14° = 27.6%	34° = 33.8%	54° = 76.8%
15° = 27.5%	35° = 36.0%	55° = 79.0%
16° = 27.4%	36° = 38.2%	56° = 81.2%
17° = 27.3%	37° = 40.4%	57° = 83.4%
18° = 27.2%	38° = 42.6%	58° = 85.6%
19° = 27.1%	39° = 44.8%	59° = 87.8%
		60° = 90.0%

(3) The following ratings are for loss of (palmar) flexion in the wrist joint:

Retained Motion/Percentage of Impairment

0° = 11.0%	24° = 7.2%	48° = 3.4%
1° = 10.9%	25° = 7.0%	49° = 3.2%
2° = 10.8%	26° = 6.8%	50° = 3.0%
3° = 10.7%	27° = 6.6%	51° = 2.9%
4° = 10.6%	28° = 6.4%	52° = 2.8%
5° = 10.5%	29° = 6.2%	53° = 2.7%
6° = 10.4%	30° = 6.0%	54° = 2.6%
7° = 10.3%	31° = 5.9%	55° = 2.5%
8° = 10.2%	32° = 5.8%	56° = 2.4%
9° = 10.1%	33° = 5.7%	57° = 2.3%
10° = 10.0%	34° = 5.6%	58° = 2.2%
11° = 9.8%	35° = 5.5%	59° = 2.1%
12° = 9.6%	36° = 5.4%	60° = 2.0%
13° = 9.4%	37° = 5.3%	61° = 1.8%
14° = 9.2%	38° = 5.2%	62° = 1.6%
15° = 9.0%	39° = 5.1%	63° = 1.4%
16° = 8.8%	40° = 5.0%	64° = 1.2%
17° = 8.6%	41° = 4.8%	65° = 1.0%
18° = 8.4%	42° = 4.6%	66° = 0.8%
19° = 8.2%	43° = 4.4%	67° = 0.6%
20° = 8.0%	44° = 4.2%	68° = 0.4%
21° = 7.8%	45° = 4.0%	69° = 0.2%
22° = 7.6%	46° = 3.8%	70° = 0.0%
23° = 7.4%	47° = 3.6%	

(4) The following ratings are for (palmar) flexion ankylosis in the wrist joint:

Joint Ankylosed at/Percentage of Impairment

0° = 30.0%	24° = 50.6%	48° = 71.2%
1° = 30.9%	25° = 51.5%	49° = 72.1%
2° = 31.8%	26° = 52.4%	50° = 73.0%
3° = 32.7%	27° = 53.3%	51° = 73.8%
4° = 33.6%	28° = 54.2%	52° = 74.6%
5° = 34.5%	29° = 55.1%	53° = 75.4%
6° = 35.4%	30° = 56.0%	54° = 76.2%
7° = 36.3%	31° = 56.8%	55° = 77.0%
8° = 37.2%	32° = 57.6%	56° = 77.8%
9° = 38.1%	33° = 58.4%	57° = 78.6%
10° = 39.0%	34° = 59.2%	58° = 79.4%
11° = 39.8%	35° = 60.0%	59° = 80.2%
12° = 40.6%	36° = 60.8%	60° = 81.0%
13° = 41.4%	37° = 61.6%	61° = 81.9%
14° = 42.2%	38° = 62.4%	62° = 82.8%
15° = 43.0%	39° = 63.2%	63° = 83.7%
16° = 43.8%	40° = 64.0%	64° = 84.6%
17° = 44.6%	41° = 64.9%	65° = 85.5%
18° = 45.4%	42° = 65.8%	66° = 86.4%
19° = 46.2%	43° = 66.7%	67° = 87.3%
20° = 47.0%	44° = 67.6%	68° = 88.2%
21° = 47.9%	45° = 68.5%	69° = 89.1%
22° = 48.8%	46° = 69.4%	70° = 90.0%
23° = 49.7%	47° = 70.3%	

(5) The following ratings are for loss of radial deviation in the wrist joint:

Retained Motion/Percentage of Impairment

0° = 4.0%	7° = 2.6%	14° = 1.2%
1° = 3.8%	8° = 2.4%	15° = 1.0%
2° = 3.6%	9° = 2.2%	16° = 0.8%
3° = 3.4%	10° = 2.0%	17° = 0.6%
4° = 3.2%	11° = 1.8%	18° = 0.4%
5° = 3.0%	12° = 1.6%	19° = 0.2%
6° = 2.8%	13° = 1.4%	20° = 0.0%

(6) The following ratings are for radial deviation ankylosis in the wrist joint:

Joint Ankylosed at/Percentage of Impairment

0° = 30%	7° = 51%	14° = 72%
1° = 33%	8° = 54%	15° = 75%
2° = 36%	9° = 57%	16° = 78%
3° = 39%	10° = 60%	17° = 81%
4° = 42%	11° = 63%	18° = 84%
5° = 45%	12° = 66%	19° = 87%
6° = 48%	13° = 69%	20° = 90%

(7) The following ratings are for loss of ulnar deviation in the wrist joint:

Retained Motion/Percentage of Impairment

0° = 5.0%	10° = 4.0%	20° = 2.0%
1° = 4.9%	11° = 3.8%	21° = 1.8%
2° = 4.8%	12° = 3.6%	22° = 1.6%
3° = 4.7%	13° = 3.4%	23° = 1.4%
4° = 4.6%	14° = 3.2%	24° = 1.2%
5° = 4.5%	15° = 3.0%	25° = 1.0%
6° = 4.4%	16° = 2.8%	26° = 0.8%
7° = 4.3%	17° = 2.6%	27° = 0.6%
8° = 4.2%	18° = 2.4%	28° = 0.4%
9° = 4.1%	19° = 2.2%	29° = 0.2%
		30° = 0.0%

(8) The following ratings are for ulnar deviation ankylosis in the wrist joint:

Joint Ankylosed at/Percentage of Impairment

0° = 30%	10° = 50%	20° = 70%
1° = 32%	11° = 52%	21° = 72%
2° = 34%	12° = 54%	22° = 74%
3° = 36%	13° = 56%	23° = 76%
4° = 38%	14° = 58%	24° = 78%
5° = 40%	15° = 60%	25° = 80%
6° = 42%	16° = 62%	26° = 82%
7° = 44%	17° = 64%	27° = 84%
8° = 46%	18° = 66%	28° = 86%
9° = 48%	19° = 68%	29° = 88%
		30° = 90%

(9) Injuries which result in a loss of pronation or supination in the wrist joint are valued under OAR 436-035-0100(4).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 10-26-04 as WCD Admin. Order 04-063, eff 1-1-05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0090 Conversion of Hand/Forearm Values to Arm Values

The following table is used to convert a loss in the hand/forearm to a loss in the arm:

Impairment of Hand Arm	Impairment of Hand Arm	Impairment of Hand Arm
1% = 1%	34% = 27%	67% = 53%
2% = 2%	35% = 28%	68% = 54%
3% = 3%	36% = 29%	69% = 55%
4% = 4%	37% = 30%	70% = 56%
5% = 4%	38% = 31%	71% = 57%
6% = 5%	39% = 31%	72% = 57%
7% = 6%	40% = 32%	73% = 58%
8% = 7%	41% = 33%	74% = 59%
9% = 8%	42% = 34%	75% = 60%
10% = 8%	43% = 34%	76% = 61%
11% = 9%	44% = 35%	77% = 61%
12% = 10%	45% = 36%	78% = 62%
13% = 11%	46% = 37%	79% = 63%
14% = 12%	47% = 38%	80% = 64%
15% = 12%	48% = 38%	81% = 64%
16% = 13%	49% = 39%	82% = 65%
17% = 14%	50% = 40%	83% = 66%
18% = 15%	51% = 41%	84% = 67%
19% = 16%	52% = 42%	85% = 68%
20% = 16%	53% = 42%	86% = 68%
21% = 17%	54% = 43%	87% = 69%
22% = 18%	55% = 44%	88% = 70%
23% = 19%	56% = 45%	89% = 71%
24% = 20%	57% = 46%	90% = 72%
25% = 20%	58% = 46%	91% = 72%
26% = 21%	59% = 47%	92% = 73%
27% = 22%	60% = 48%	93% = 74%
28% = 23%	61% = 49%	94% = 75%
29% = 23%	62% = 49%	95% = 76%
30% = 24%	63% = 50%	96% = 76%
31% = 25%	64% = 51%	97% = 77%
32% = 26%	65% = 52%	98% = 78%
33% = 27%	66% = 53%	99% = 79%
		100% = 79%

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 10-26-04 as WCD Admin. Order 04-063, eff 1-1-05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0100 Arm

(1) The following ratings are for loss of flexion in the elbow joint (150° describes the arm in full flexion):

Retained Motion/Percentage of Impairment

0° = 39.0%	38° = 29.4%	76° = 19.2%	114° = 9.2%
1° = 38.7%	39° = 29.2%	77° = 18.9%	115° = 9.0%
2° = 38.4%	40° = 29.0%	78° = 18.6%	116° = 8.8%
3° = 38.1%	41° = 28.7%	79° = 18.3%	117° = 8.6%
4° = 37.8%	42° = 28.4%	80° = 18.0%	118° = 8.4%
5° = 37.5%	43° = 28.1%	81° = 17.8%	119° = 8.2%
6° = 37.2%	44° = 27.8%	82° = 17.6%	120° = 8.0%
7° = 36.9%	45° = 27.5%	83° = 17.4%	121° = 7.7%
8° = 36.6%	46° = 27.2%	84° = 17.2%	122° = 7.4%
9° = 36.3%	47° = 26.9%	85° = 17.0%	123° = 7.1%
10° = 36.0%	48° = 26.6%	86° = 16.8%	124° = 6.8%
11° = 35.8%	49° = 26.3%	87° = 16.6%	125° = 6.5%
12° = 35.6%	50° = 26.0%	88° = 16.4%	126° = 6.2%
13° = 35.4%	51° = 25.7%	89° = 16.2%	127° = 5.9%
14° = 35.2%	52° = 25.4%	90° = 16.0%	128° = 5.6%
15° = 35.0%	53° = 25.1%	91° = 15.7%	129° = 5.3%
16° = 34.8%	54° = 24.8%	92° = 15.4%	130° = 5.0%
17° = 34.6%	55° = 24.5%	93° = 15.1%	131° = 4.8%
18° = 34.4%	56° = 24.2%	94° = 14.8%	132° = 4.6%
19° = 34.2%	57° = 23.9%	95° = 14.5%	133° = 4.4%
20° = 34.0%	58° = 23.6%	96° = 14.2%	134° = 4.2%
21° = 33.7%	59° = 23.3%	97° = 13.9%	135° = 4.0%
22° = 33.4%	60° = 23.0%	98° = 13.6%	136° = 3.8%
23° = 33.1%	61° = 22.8%	99° = 13.3%	137° = 3.6%
24° = 32.8%	62° = 22.6%	100° = 13.0%	138° = 3.4%
25° = 32.5%	63° = 22.4%	101° = 12.7%	139° = 3.2%

26° = 32.2%	64° = 22.2%	102° = 12.4%	140° = 3.0%
27° = 31.9%	65° = 22.0%	103° = 12.1%	141° = 2.7%
28° = 31.6%	66° = 21.8%	104° = 11.8%	142° = 2.4%
29° = 31.3%	67° = 21.6%	105° = 11.5%	143° = 2.1%
30° = 31.0%	68° = 21.4%	106° = 11.2%	144° = 1.8%
31° = 30.8%	69° = 21.2%	107° = 10.9%	145° = 1.5%
32° = 30.6%	70° = 21.0%	108° = 10.6%	146° = 1.2%
33° = 30.4%	71° = 20.7%	109° = 10.3%	147° = 0.9%
34° = 30.2%	72° = 20.4%	110° = 10.0%	148° = 0.6%
35° = 30.0%	73° = 20.1%	111° = 9.8%	149° = 0.3%
36° = 29.8%	74° = 19.8%	112° = 9.6%	150° = 0.0%
37° = 29.6%	75° = 19.5%	113° = 9.4%	

(2) The following ratings are for loss of extension in the elbow joint (0° describes the arm in full extension):

Retained Motion/Percentage of Impairment

0° = 0.0%	38° = 7.6%	76° = 15.2%	114° = 22.8%
1° = 0.2%	39° = 7.8%	77° = 15.4%	115° = 23.0%
2° = 0.4%	40° = 8.0%	78° = 15.6%	116° = 23.2%
3° = 0.6%	41° = 8.2%	79° = 15.8%	117° = 23.4%
4° = 0.8%	42° = 8.4%	80° = 16.0%	118° = 23.6%
5° = 1.0%	43° = 8.6%	81° = 16.2%	119° = 23.8%
6° = 1.2%	44° = 8.8%	82° = 16.4%	120° = 24.0%
7° = 1.4%	45° = 9.0%	83° = 16.6%	121° = 24.2%
8° = 1.6%	46° = 9.2%	84° = 16.8%	122° = 24.4%
9° = 1.8%	47° = 9.4%	85° = 17.0%	123° = 24.6%
10° = 2.0%	48° = 9.6%	86° = 17.2%	124° = 24.8%
11° = 2.2%	49° = 9.8%	87° = 17.4%	125° = 25.0%
12° = 2.4%	50° = 10.0%	88° = 17.6%	126° = 25.2%
13° = 2.6%	51° = 10.2%	89° = 17.8%	127° = 25.4%
14° = 2.8%	52° = 10.4%	90° = 18.0%	128° = 25.6%
15° = 3.0%	53° = 10.6%	91° = 18.2%	129° = 25.8%
16° = 3.2%	54° = 10.8%	92° = 18.4%	130° = 26.0%
17° = 3.4%	55° = 11.0%	93° = 18.6%	131° = 26.2%
18° = 3.6%	56° = 11.2%	94° = 18.8%	132° = 26.4%
19° = 3.8%	57° = 11.4%	95° = 19.0%	133° = 26.6%
20° = 4.0%	58° = 11.6%	96° = 19.2%	134° = 26.8%
21° = 4.2%	59° = 11.8%	97° = 19.4%	135° = 27.0%
22° = 4.4%	60° = 12.0%	98° = 19.6%	136° = 27.2%
23° = 4.6%	61° = 12.2%	99° = 19.8%	137° = 27.4%
24° = 4.8%	62° = 12.4%	100° = 20.0%	138° = 27.6%
25° = 5.0%	63° = 12.6%	101° = 20.2%	139° = 27.8%
26° = 5.2%	64° = 12.8%	102° = 20.4%	140° = 28.0%
27° = 5.4%	65° = 13.0%	103° = 20.6%	141° = 28.2%
28° = 5.6%	66° = 13.2%	104° = 20.8%	142° = 28.4%
29° = 5.8%	67° = 13.4%	105° = 21.0%	143° = 28.6%
30° = 6.0%	68° = 13.6%	106° = 21.2%	144° = 28.8%
31° = 6.2%	69° = 13.8%	107° = 21.4%	145° = 29.0%
32° = 6.4%	70° = 14.0%	108° = 21.6%	146° = 29.2%
33° = 6.6%	71° = 14.2%	109° = 21.8%	147° = 29.4%
34° = 6.8%	72° = 14.4%	110° = 22.0%	148° = 29.6%
35° = 7.0%	73° = 14.6%	111° = 22.2%	149° = 29.8%
36° = 7.2%	74° = 14.8%	112° = 22.4%	150° = 30.0%
37° = 7.4%	75° = 15.0%	113° = 22.6%	

(3) Ankylosis of the elbow in flexion or extension is rated as follows:

Joint Ankylosed at/Percentage of Impairment

0° = 65.0%	38° = 59.4%	76° = 53.8%	114° = 62.6%
1° = 64.9%	39° = 59.2%	77° = 53.6%	115° = 63.5%
2° = 64.8%	40° = 59.0%	78° = 53.4%	116° = 64.4%
3° = 64.7%	41° = 58.9%	79° = 53.2%	117° = 65.3%
4° = 64.6%	42° = 58.8%	80° = 53.0%	118° = 66.2%
5° = 64.5%	43° = 58.7%	81° = 52.9%	119° = 67.1%
6° = 64.4%	44° = 58.6%	82° = 52.8%	120° = 68.0%
7° = 64.3%	45° = 58.5%	83° = 52.7%	121° = 68.9%
8° = 64.2%	46° = 58.4%	84° = 52.6%	122° = 79.8%
9° = 64.1%	47° = 58.3%	85° = 52.5%	123° = 70.7%
10° = 64.0%	48° = 58.2%	86° = 52.4%	124° = 71.6%
11° = 63.8%	49° = 58.1%	87° = 52.3%	125° = 72.5%
12° = 63.6%	50° = 58.0%	88° = 52.2%	126° = 73.4%
13° = 63.4%	51° = 57.8%	89° = 52.1%	127° = 74.3%
14° = 63.2%	52° = 57.6%	90° = 52.0%	128° = 75.2%
15° = 63.0%	53° = 57.4%	91° = 51.8%	129° = 76.1%
16° = 62.8%	54° = 57.2%	92° = 51.6%	130° = 77.0%
17° = 62.6%	55° = 57.0%	93° = 51.4%	131° = 77.9%
18° = 62.4%	56° = 56.8%	94° = 51.2%	132° = 78.8%
19° = 62.2%	57° = 56.6%	95° = 51.0%	133° = 79.7%
20° = 62.0%	58° = 56.4%	96° = 50.8%	134° = 80.6%
21° = 61.9%	59° = 56.2%	97° = 50.6%	135° = 81.5%
22° = 61.8%	60° = 56.0%	98° = 50.4%	136° = 82.4%
23° = 61.7%	61° = 55.9%	99° = 50.2%	137° = 83.3%
24° = 61.6%	62° = 55.8%	100° = 50.0%	138° = 84.2%
25° = 61.5%	63° = 55.7%	101° = 50.9%	139° = 85.1%
26° = 61.4%	64° = 55.6%	102° = 51.8%	140° = 86.0%
27° = 61.3%	65° = 55.5%	103° = 52.7%	141° = 86.9%
28° = 61.2%	66° = 55.4%	104° = 53.6%	142° = 87.8%
29° = 61.1%	67° = 55.3%	105° = 54.5%	143° = 88.7%
30° = 61.0%	68° = 55.2%	106° = 55.4%	144° = 89.6%
31° = 60.8%	69° = 55.1%	107° = 56.3%	145° = 90.5%
32° = 60.6%	70° = 55.0%	108° = 57.2%	146° = 91.4%
33° = 60.4%	71° = 54.8%	109° = 58.1%	147° = 92.3%
34° = 60.2%	72° = 54.6%	110° = 59.0%	148° = 93.2%
35° = 60.0%	73° = 54.4%	111° = 59.9%	149° = 94.1%
36° = 59.8%	74° = 54.2%	112° = 60.8%	150° = 95.0%
37° = 59.6%	75° = 54.0%	113° = 61.7%	

(4) The following ratings are for loss of pronation or supination in the elbow joint. If there are losses in both pronation and supination, rate each separately and add the values:

Retained Motion/Percentage of Impairment

0° = 13.0%	27° = 8.6%	54° = 4.2%
1° = 12.8%	28° = 8.4%	55° = 4.0%
2° = 12.6%	29° = 8.2%	56° = 3.8%
3° = 12.4%	30° = 8.0%	57° = 3.6%
4° = 12.2%	31° = 7.9%	58° = 3.4%
5° = 12.0%	32° = 7.8%	59° = 3.2%
6° = 11.8%	33° = 7.7%	60° = 3.0%

7° = 11.6%	34° = 7.6%	61° = 2.9%
8° = 11.4%	35° = 7.5%	62° = 2.8%
9° = 11.2%	36° = 7.4%	63° = 2.7%
10° = 11.0%	37° = 7.3%	64° = 2.6%
11° = 10.9%	38° = 7.2%	65° = 2.5%
12° = 10.8%	39° = 7.1%	66° = 2.4%
13° = 10.7%	40° = 7.0%	67° = 2.3%
14° = 10.6%	41° = 6.8%	68° = 2.2%
15° = 10.5%	42° = 6.6%	69° = 2.1%
16° = 10.4%	43° = 6.4%	70° = 2.0%
17° = 10.3%	44° = 6.2%	71° = 1.8%
18° = 10.2%	45° = 6.0%	72° = 1.6%
19° = 10.1%	46° = 5.8%	73° = 1.4%
20° = 10.0%	47° = 5.6%	74° = 1.2%
21° = 9.8%	48° = 5.4%	75° = 1.0%
22° = 9.6%	49° = 5.2%	76° = 0.8%
23° = 9.4%	50° = 5.0%	77° = 0.6%
24° = 9.2%	51° = 4.8%	78° = 0.4%
25° = 9.0%	52° = 4.6%	79° = 0.2%
26° = 8.8%	53° = 4.4%	80° = 0.0%

(5) Ankylosis of the elbow in pronation or supination will be rated as follows:

Joint Ankylosed at/Percentage of Impairment

0° = 65.0%	27° = 75.1%	54° = 85.6%
1° = 65.4%	28° = 75.4%	55° = 86.0%
2° = 65.8%	29° = 75.7%	56° = 86.4%
3° = 66.2%	30° = 76.0%	57° = 86.8%
4° = 66.6%	31° = 76.4%	58° = 87.2%
5° = 67.0%	32° = 76.8%	59° = 87.6%
6° = 67.4%	33° = 77.2%	60° = 88.0%
7° = 67.8%	34° = 77.6%	61° = 88.3%
8° = 68.2%	35° = 78.0%	62° = 88.6%
9° = 68.6%	36° = 78.4%	63° = 88.9%
10° = 69.0%	37° = 78.8%	64° = 89.2%
11° = 69.4%	38° = 79.2%	65° = 89.5%
12° = 69.8%	39° = 79.6%	66° = 89.8%
13° = 70.2%	40° = 80.0%	67° = 90.1%
14° = 70.6%	41° = 80.4%	68° = 90.4%
15° = 71.0%	42° = 80.8%	69° = 90.7%
16° = 71.4%	43° = 81.2%	70° = 91.0%
17° = 71.8%	44° = 81.6%	71° = 91.4%
18° = 72.2%	45° = 82.0%	72° = 91.8%
19° = 72.6%	46° = 82.4%	73° = 92.2%
20° = 73.0%	47° = 82.8%	74° = 92.6%
21° = 73.3%	48° = 83.2%	75° = 93.0%
22° = 73.6%	49° = 83.6%	76° = 93.4%
23° = 73.9%	50° = 84.0%	77° = 93.8%
24° = 74.2%	51° = 84.4%	78° = 94.2%
25° = 74.5%	52° = 84.8%	79° = 94.6%
26° = 74.8%	53° = 85.2%	80° = 95.0%

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 10-26-04 as WCD Admin. Order 04-063, eff 1-1-05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0110 Other Upper Extremity Findings

(1) Loss of palmar sensation in the hand, finger(s), or thumb is rated based on the location and quality of the loss, and is measured by the two-point discrimination method.

(a) Sensation is determined by using any instrumentation that allows for measuring the distance between two pin pricks applied at the same time (two-point) and using the following procedure:

(A) With the worker's eyes closed, the examiner touches the tip of the instrument to the digit in the longitudinal axis on the radial or ulnar side.

(B) The worker indicates whether one or two points are felt.

(C) A varied series of one or two points are applied.

(D) Testing is started distally and proceeds proximally to determine the longitudinal level of involvement.

(E) The ends of the testing device are set first at 15 mm apart and the distance is progressively decreased as accurate responses are obtained.

(F) The minimum distance at which the individual can accurately discriminate between one and two point tests in two out of three applications is recorded for each area.

(b) If enough sensitivity remains to distinguish two pin pricks applied at the same time (two point), the following apply:

Finding	Grade of sensation
6 millimeters apart or less:	normal
7-10 millimeters:	less than normal
11-15 millimeters:	protective sensation
Greater than 15 millimeters:	total loss

(c) In determining sensation findings for a digit that has been resected or amputated, the value is established by comparing the remaining overall length of the digit to the table in subsection (1)(d) of this rule and rating the length equivalency.

For example: Amputation of 1/2 the middle phalanx of the index finger with total sensory loss extending from the level of amputation to the metacarpophalangeal joint, results in a value for 1/2 the digit or 33%.

(d) Loss of sensation in the finger(s) or thumb is rated as follows:

Level of loss and percentage of impairment						
	Whole digit MP joint	1/2 Proximal phalanx	PIP joint	1/2 Digit or IP joint of the thumb	DIP joint	1/2 Distal phalanx
Thumb						
Less than normal:	25	19	NA	12	NA	8
Radial side only:	10	8	NA	5	NA	3
Ulnar side only:	17	12	NA	7	NA	5
Protective sensation:	38	28	NA	17	NA	12
Radial side only:	17	12	NA	7	NA	5
Ulnar side only:	25	18	NA	11	NA	7
Total loss of sensation:	50	37	NA	23	NA	15
Radial side only:	23	16	NA	9	NA	6
Ulnar side only:	35	25	NA	15	NA	10
Index finger						
Less than normal:	25	23	20	17	13	8
Radial side only:	17	15	13	11	8	5
Ulnar side only:	10	9	8	7	5	3
Protective sensation:	38	35	30	25	19	12
Radial side only:	25	23	20	17	12	7
Ulnar side only:	17	15	13	10	8	5
Total loss of sensation:	50	45	39	33	24	15
Radial side only:	35	31	27	22	16	10
Ulnar side only:	23	20	17	14	10	6
Middle finger						
Less than normal:	25	23	20	17	13	8
Radial side only:	17	15	13	11	8	5
Ulnar side only:	10	9	8	7	5	3
Protective sensation:	38	35	30	25	19	12
Radial side only:	25	23	20	17	12	7
Ulnar side only:	17	15	13	10	8	5
Total loss of sensation:	50	45	39	33	24	15
Radial side only:	35	31	27	22	16	10
Ulnar side only:	23	20	17	14	10	6

Level of loss and percentage of impairment						
	Whole digit MP joint	1/2 Proximal phalanx	PIP joint	1/2 Digit or IP joint of the thumb	DIP joint	1/2 Distal phalanx
Ring finger						
Less than normal:	25	23	20	17	13	8
Radial side only:	17	15	13	11	8	5
Ulnar side only:	10	9	8	7	5	3
Protective sensation:	38	35	30	25	19	12
Radial side only:	25	23	20	17	12	7
Ulnar side only:	17	15	13	10	8	5
Total loss of sensation:	50	45	39	33	24	15
Radial side only:	35	31	27	22	16	10
Ulnar side only:	23	20	17	14	10	6
Little finger						
Less than normal:	25	23	20	17	13	8
Radial side only:	10	9	8	7	5	3
Ulnar side only:	17	15	13	11	8	5
Protective sensation:	38	35	30	25	19	12
Radial side only:	17	15	13	10	8	5
Ulnar side only:	25	23	20	17	12	7
Total loss of sensation:	50	45	39	33	24	15
Radial side only:	23	20	17	14	10	6
Ulnar side only:	35	31	27	22	16	10
(NA = Not applicable)						

(e) If the level of the loss is less than 1/2 the distal phalanx or falls between the levels in subsection (d) of this section, rate at the next highest (or more proximal) level.

(f) In determining sensation impairment in a digit in which the sensation loss does not extend to the distal end of the digit, the value is established by determining the value for loss from the distal end of the digit to the proximal location of the loss, and subtracting the value for loss from the distal end of the digit to the distal location of the loss.

Example: Grade 2 sensation in the index finger between the PIP joint and the MP joint:

Loss from distal end of the finger to the MP joint (proximal location of loss) 25%

Minus loss from distal end of the finger to the PIP joint (distal location of loss) 20%

Equals loss between MP and PIP 5%

(g) Sensation loss on the palmar side of the hand is rated as follows:

	Total loss of sensation	Protective sensation
Palmar median nerve	15%	11%
Palmar ulnar nerve	7%	5%

(h) Loss of sensation or hypersensitivity on the dorsal side of the hand, fingers or thumb is not considered a loss of function, so no value is allowed.

(i) Sensory loss or hypersensitivity in the forearm or arm is not considered a loss of function, therefore no value is allowed.

(j) When there are multiple losses of palmar sensation in a single body part (e.g., hand, finger(s), or thumb), the impairment values are first combined for an overall loss of sensation value for the individual digit or hand. This value is then combined with other impairment values for that digit or hand prior to conversion.

(k) Hypersensitivity is valued using the above loss of sensation tables. Mild hypersensitivity is valued at the equivalent impairment level as less than normal sensation, moderate hypersensitivity the equivalent of protective sensation loss, and severe hypersensitivity the equivalent of a total loss of sensation.

(l) When there is a loss of use or function due to hypersensitivity and decreased two-point discrimination (i.e., sensation loss), both conditions are rated.

(2) When surgery or an injury results in arm length discrepancies involving the injured arm, the following values are given on the affected arm for the length discrepancy:

Discrepancy in inches	Arm impairment
Less than 1 inch	0%
1 inch or more, but less than 2 inches	5%
2 inches or more but less than 3 inches	10%
3 inches or more but less than 4 inches	15%
4 inches or more	20%

(3) Joint instability in the finger(s), thumb, hand, or wrist is rated based on the body part affected:

	Finger			Thumb		Hand	Wrist
	MP	**PIP**	**DIP**	**MP**	**IP**	**CMC**	
Mild: Less than 10°	20%	16%	9%	2%	3%	15%	15%
Moderate: 10° to 20°	40%	32%	18 %	4%	6%	30%	30%
Severe: Greater than 20°	60%	48%	27 %	6%	9%	45%	45%

(4) Lateral deviation or malalignment of the upper extremity is valued as follows:

(a) Increased lateral deviation at the elbow is determined as follows:

Severity of deviation	Arm impairment
Mild: less than 20°	7%
Moderate: 20° - 30°	14%
Severe: Greater than 30°	21%

(b) Fracture resulting in angulation or malalignment, other than at the elbow, is determined as follows:

Deformity	Impairment
Radius or ulna	10% forearm
Humerus	25% arm

(c) Rotational, lateral, dorsal, or palmar deformity of the thumb receives a value of 10% of the thumb for each type of deformity.

(d) Rotational, lateral, dorsal, or palmar deformity of a finger receives a value of 10% for the finger for each type of deformity.

(5) Surgery on the upper extremity is valued as follows:

(a)	**Finger/thumb surgery**	**Finger impairment**
	Arthroplasty	1/2 the lowest ankylosis value for the involved joint
(b)	**Forearm/hand surgery**	**Forearm/hand impairment**
	Carpometacarpal arthroplasty	1/2 the lowest ankylosis value for the involved joint
	Carpal bone fusion	5% each (Add values up to 30% maximum)
	Loss of all or part of metacarpal	10%
	Prosthetic carpal bone replacement	5%
	Carpal bone removal, (any portion) without replacement	5% maximum for each carpal bone
	Prosthetic distal ulnar replacement	5%
	Distal ulnar resection, without replacement	10%
(c)	**Arm surgery**	**Arm impairment**
	Prosthetic radial head replacement	10%
	Radial head resection, without replacement	15%
	Prosthetic elbow joint replacement	35%
	Humeral head replacement	15%

(6) Dermatological conditions, including burns, which are limited to the arm, forearm, hand, fingers, or thumb are rated based on the body part affected. The percentages indicated in the classes below are applied to the affected body part(s), e.g. a

Class 1 dermatological condition of the thumb is 3% of the thumb, or a Class 1 dermatological condition of the hand is 3% of the hand, or a Class 1 dermatological condition of the arm is 3% of the arm. Contact dermatitis of an upper extremity is rated in this section unless it is an allergic systemic reaction, which is also rated under OAR 436-035-0450. Contact dermatitis for a body part other than the upper or lower extremities is rated under OAR 436-035-0440. Impairments may or may not show signs or symptoms of skin disorder upon examination but are rated under the following classes:

(a) **Class 1:** 3% for the affected body part if treatment results in no more than minimal limitation in the performance of activities of daily living (ADL), although exposure to physical or chemical agents may temporarily increase limitations.

(b) **Class 2:** 15% for the affected body part if intermittent treatments and prescribed examinations are required, and the worker has some limitations in the performance of ADL.

(c) **Class 3:** 38% for the affected body part if regularly prescribed examinations and continuous treatments are required, and the worker has many limitations in the performance of ADL.

(d) **Class 4:** 68% for the affected body part if continuous prescribed treatments are required. The treatment may include periodically having the worker stay home or admitting the worker to a care facility, and the worker has many limitations in the performance of ADL.

(e) **Class 5:** 90% for the affected body part if continuous prescribed treatment is required. The treatment necessitates having the worker stay home or being permanently admitted to a care facility, and the worker has severe limitations in the performance of ADL.

(7) Vascular dysfunction of the upper extremity is valued based on the affected body part, using the following classification table:

(a) **Class 1**: 3% for the affected body part if the worker experiences only transient edema; and on physical examination, the findings are limited to the following: loss of pulses, minimal loss of subcutaneous tissue of fingertips, calcification of arteries as detected by radiographic examination, asymptomatic dilation of arteries or veins (not requiring surgery and not resulting in curtailment of activity); or cold intolerance (e.g., Raynaud's phenomenon) which results in a loss of use or function that occurs with exposure to temperatures below freezing (0° centigrade).

(b) **Class 2**: 15% for the affected body part if the worker experiences intermittent pain with repetitive exertional activity; or there is persistent moderate edema incompletely controlled by elastic supports; or there are signs of vascular damage such as a healed stump of an amputated digit, with evidence of persistent vascular disease, or a healed ulcer; or cold intolerance (e.g., Raynaud's phenomenon) which results in a loss of use or function that occurs on exposure to temperatures below 4° centigrade.

(c) **Class 3**: 35% for the affected body part if the worker experiences intermittent pain with moderate upper extremity usage; or there is marked edema incompletely controlled by elastic supports; or there are signs of vascular damage such as a healed amputation of two or more digits, with evidence of persistent vascular disease, or superficial ulceration; or cold intolerance (e.g., Raynaud's phenomenon) which results in a loss of use or function that occurs on exposure to temperatures below 10° centigrade.

(d) **Class 4**: 63% for the affected body part if the worker experiences intermittent pain upon mild upper extremity usage; or there is marked edema that cannot be controlled by elastic supports; or there are signs of vascular damage such as an amputation at or above the wrist, with evidence of persistent vascular disease, or persistent widespread or deep ulceration involving one extremity; or cold intolerance (e.g., Raynaud's phenomenon) which results in a loss of use or function that occurs on exposure to temperatures below 15° centigrade.

(e) **Class 5**: 88% for the affected body part if the worker experiences constant and severe pain at rest; or there are signs of vascular damage involving more than one extremity such as amputation at or above the wrist, or amputation of all digits involving more than one extremity with evidence of persistent vascular disease, or persistent widespread deep ulceration involving more than one extremity; or cold intolerance such as Raynaud's phenomenon which results in a loss of use or function that occurs on exposure to temperatures below 20° centigrade.

(f) If partial amputation of the affected body part occurs as a result of vascular disease, the impairment values are rated separately.

(8) Neurological dysfunction resulting in cold intolerance in the upper extremity is valued under the affected body part using the same classifications for cold intolerance due to vascular dysfunction in section (7) of this rule.

(9) Injuries to unilateral spinal nerve roots or brachial plexus with resultant loss of strength in the arm, forearm or hand are rated based on the specific nerve root which supplies (innervates) the weakened muscle(s), as described in the following table and modified under OAR 436-035-0011(7):

(a) Spinal nerve root arm impairment

C-5	30%
C-6	35%
C-7	35%
C-8	45%
T-1	20%

(b) For loss of strength in bilateral extremities, each extremity is rated separately.

(10) When a spinal nerve root or brachial plexus are not injured, valid loss of strength in the arm, forearm or hand is valued as if the peripheral nerve supplying (innervating) the muscle(s) demonstrating the decreased strength was impaired, as described in the following table and as modified under OAR 436-035-0011(7).

Peripheral nerve	Forearm impairment
Median (above mid-forearm below elbow)	69%
Median (below mid-forearm)	44%
Radial (musculospiral) (forearm with sparing of triceps)	50%
Ulnar (above mid-forearm)	44%
Ulnar (below mid-forearm)	31%
	Arm impairment
Radial (upper arm with loss of triceps)	55%
Radial (triceps only)	25%
Musculocutaneous	25%

Example 1: A worker suffers a rupture of the biceps tendon. Upon recovery, the attending physician reports 4/5 strength of the biceps. The biceps is innervated by the musculocutaneous nerve which has a 25% impairment value. 4/5 strength, under OAR 436-035-0011(7), is 20%. Final impairment is determined by multiplying 25% by 20% for a final value of 5% impairment of the arm.

Example 2: A worker suffers a laceration of the median nerve below the mid-forearm. Upon recovery, the attending physician reports 3/5 strength in the forearm. The median nerve below the mid-forearm has a 44% impairment value. 3/5 strength, under OAR 436-035-0011(7), is 50%. Final impairment is determined by multiplying 44% by 50% for a final value of 22% impairment of the forearm.

(a) Loss of strength due to an injury in a single finger or thumb receives a value of zero, unless the strength loss is due to a compensable condition that is proximal to the digit.

(b) Decreased strength due to an amputation receives no rating for weakness in addition to that given for the amputation.

(c) Decreased strength due to a loss in range of motion receives no rating for weakness in addition to that given for the loss of range of motion.

(d) When loss of strength is present in the shoulder, refer to OAR 436-035-0330 for determination of the impairment.

(11) For motor loss in any part of an arm that is due to brain or spinal cord damage, impairment is valued as follows:

(a) **Class 1**: 14% when the involved extremity can be used for self care, grasping, and holding but has difficulty with digital dexterity.

(b) **Class 2**: 34% when the involved extremity can be used for self care, grasping and holding objects with difficulty, but has no digital dexterity.

(c) **Class 3**: 55% when the involved extremity can be used but has difficulty with self care activities.

(d) **Class 4**: 100% when the involved extremity cannot be used for self care.

(e) When a value is granted under this section, additional impairment values are not allowed for strength loss, chronic condition, or reduced range of motion in the same extremity because they are included in the impairment values shown in this section.

(f) For bilateral extremity loss, each extremity is rated separately.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0115 Conversion of Upper Extremity Values to Whole Person Values

(1) The tables in this rule are used to convert losses in the upper extremity to a whole person (WP) value for claims with a date of injury on or after January 1, 2005.

(2) The following table is used to convert losses in the thumb and fingers to a whole person (WP) value.

Thumb WP	Index WP	Middle WP
1-9% = 1%	1-18% = 1%	1-21% = 1%
10-16% = 2%	19-31% = 2%	22-35% = 2%
17-23% = 3%	32-43% = 3%	36-49% = 3%
24-29% = 4%	44-56% = 4%	50-64% = 4%
30-36% = 5%	57-68% = 5%	65-78% = 5%
37-43% = 6%	69-81% = 6%	79-92% = 6%
44-49% = 7%	82-93% = 7%	93-100% = 7%
50-56% = 8%	94-100% = 8%	
57-63% = 9%		**Ring WP**
64-69% = 10%		1-49% = 1%
70-76% = 11%		50-83% = 2%
77-83% = 12%		84-100% = 3%
84-89% = 13%		**Little WP**
90-96% = 14%		1-74% = 1%
97-100% = 15%		75-100% = 2%

(3) The following table is used to convert a loss in a hand/forearm to a whole person (WP) value.

Hand WP	Hand WP	Hand WP
1-3% = 1%	36-37% = 17%	70-71% = 33%
4-5% = 2%	38-39% = 18%	72-73% = 34%
6-7% = 3%	40-41% = 19%	74-75% = 35%
8-9% = 4%	42-43% = 20%	76-77% = 36%
10-11% = 5%	44-45% = 21%	78-79% = 37%
12-13% = 6%	46-47% = 22%	80-81% = 38%
14-15% = 7%	48-49% = 23%	82-84% = 39%
16-18% = 8%	50-52% = 24%	85-86% = 40%
19-20% = 9%	53-54% = 25%	87-88% = 41%
21-22% = 10%	55-56% = 26%	89-90% = 42%
23-24% = 11%	57-58% = 27%	91-92% = 43%
25-26% = 12%	59-60% = 28%	93-94% = 44%
27-28% = 13%	61-62% = 29%	95-96% = 45%
29-30% = 14%	63-64% = 30%	97-98% = 46%
31-32% = 15%	65-67% = 31%	99-100% = 47%
33-35% = 16%	68-69% = 32%	

(4) The following table is used to convert a loss in the arm to a whole person (WP) value.

Arm	WP	Arm	WP
1-2% =	1%	51-52% =	31%
3-4% =	2%	53-54% =	32%
5% =	3%	55% =	33%
6-7% =	4%	56-57% =	34%
8-9% =	5%	58-59% =	35%
10% =	6%	60% =	36%
11-12% =	7%	61-62% =	37%
13-14% =	8%	63-64% =	38%
15% =	9%	65% =	39%
16-17% =	10%	66-67% =	40%
18-19% =	11%	68-69% =	41%
20% =	12%	70% =	42%
21-22% =	13%	71-72% =	43%
23-24% =	14%	73-74% =	44%
25% =	15%	75% =	45%
26-27% =	16%	76-77% =	46%
28-29% =	17%	78-79% =	47%
30% =	18%	80% =	48%
31-32% =	19%	81-82% =	49%
33-34% =	20%	83-84% =	50%
35% =	21%	85% =	51%
36-37% =	22%	86-87% =	52%
38-39% =	23%	88-89% =	53%
40% =	24%	90% =	54%
41-42% =	25%	91-92% =	55%
43-44% =	26%	93-94% =	56%
45% =	27%	95% =	57%
46-47% =	28%	96-97% =	58%
48-49% =	29%	98-99% =	59%
50% =	30%	100% =	60%

Stat. Auth.: ORS 656.726:
Stats. Implemented: ORS 656:
Hist.: Filed 10-26-04 as WCD Admin. Order 04-063, eff 1-1-05

436-035-0130 Parts of the Lower Extremities

(1) The leg begins with the femoral head and includes the knee joint.

(2) The foot begins just distal to the knee joint and extends just proximal to the metatarsophalangeal joints of the toes.

(3) The toes begin at the metatarsophalangeal joints. Disabilities in the toes are not converted to foot values, regardless of the number of toes involved, unless the foot is also impaired.

Stat. Auth.: ORS 656.726:
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726:
Hist.: Amended 10-26-04 as WCD Admin. Order 04-063, eff 1-1-05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0140 Amputations in the Lower Extremities

(1) Amputation at or above the knee joint (up to and including the femoral head) is rated at 100% loss of the leg.

(2) Amputation of the foot:

(a) At or above the tibio-talar joint but below the knee joint is rated at 100% loss of the foot.

(b) At the tarsometatarsal joints is rated at 75% loss of the foot.

(c) At the mid-metatarsal area is rated at 50% of the foot.

(d) Loss of all or part of a metatarsal is rated at 10% of the foot.

(3) Amputation of the great toe:

(a) At the interphalangeal joint is rated at 50% loss of the great toe. Between the interphalangeal joint and the tip will be rated in 5% increments, starting with zero for no loss of the tip.

(b) At the metatarsophalangeal joint is rated at 100% loss of the great toe. Between the interphalangeal joint and the metatarsophalangeal joint will be rated in 5% increments, starting with 50% of the great toe for amputation at the interphalangeal joint.

(4) Amputation of the second through fifth toes:

(a) At the distal interphalangeal joint is rated at 50% loss of the toe. Between the distal interphalangeal and the tip will be rated in 5% increments, starting with zero for no loss of the tip.

(b) At the proximal interphalangeal joint is rated at 75% loss of the toe. Between the proximal interphalangeal joint and the distal interphalangeal joint will be rated in 5% increments, starting with 50% of the toe for amputation at the distal interphalangeal joint.

(c) At the metatarsophalangeal joint is rated at 100% loss of the toe. Between the proximal interphalangeal joint and the metatarsophalangeal joint will be rated in 5% increments, starting with 75% of the toe for amputation at the proximal interphalangeal joint.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 10-26-04 as WCD Admin. Order 04-063, eff 1-1-05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0150 Great Toe

(1) The following ratings are for loss of plantar flexion in the interphalangeal joint of the great toe:

Retained Motion/Percentage of Impairment

0° = 45.0%	10° = 30.0%	20° = 15.0%
1° = 43.5%	11° = 28.5%	21° = 13.5%
2° = 42.0%	12° = 27.0%	22° = 12.0%
3° = 40.5%	13° = 25.5%	23° = 10.5%
4° = 39.0%	14° = 24.0%	24° = 9.0%
5° = 37.5%	15° = 22.5%	25° = 7.5%
6° = 36.0%	16° = 21.0%	26° = 6.0%
7° = 34.5%	17° = 19.5%	27° = 4.5%
8° = 33.0%	18° = 18.0%	28° = 3.0%
9° = 31.5%	19° = 16.5%	29° = 1.5%
		30° = 0.0%

(2) The following ratings are for plantarflexion ankylosis of the interphalangeal joint of the great toe:

Joint Ankylosed at/Percentage of Impairment

0° = 45%	10° = 55%	20° = 65%
1° = 46%	11° = 56%	21° = 66%
2° = 47%	12° = 57%	22° = 67%

3° = 48%	13° = 58%	23° = 68%
4° = 49%	14° = 59%	24° = 69%
5° = 50%	15° = 60%	25° = 70%
6° = 51%	16° = 61%	26° = 71%
7° = 52%	17° = 62%	27° = 72%
8° = 53%	18° = 63%	28° = 73%
9° = 54%	19° = 64%	29° = 74%
		30° = 75%

(3) The following ratings are for loss of dorsiflexion (extension) in the metatarsophalangeal joint of the great toe:

Retained Motion/Percentage of Impairment

0° = 34.0%	17° = 23.1%	34° = 11.2%
1° = 33.4%	18° = 22.4%	35° = 10.5%
2° = 32.8%	19° = 21.7%	36° = 9.8%
3° = 32.2%	20° = 21.0%	37° = 9.1%
4° = 31.6%	21° = 20.3%	38° = 8.4%
5° = 31.0%	22° = 19.6%	39° = 7.7%
6° = 30.4%	23° = 18.9%	40° = 7.0%
7° = 29.8%	24° = 18.2%	41° = 6.3%
8° = 29.2%	25° = 17.5%	42° = 5.6%
9° = 28.6%	26° = 16.8%	43° = 4.9%
10° = 28.0%	27° = 16.1%	44° = 4.2%
11° = 27.3%	28° = 15.4%	45° = 3.5%
12° = 26.6%	29° = 14.7%	46° = 2.8%
13° = 25.9%	30° = 14.0%	47° = 2.1%
14° = 25.2%	31° = 13.3%	48° = 1.4%
15° = 24.5%	32° = 12.6%	49° = 0.7%
16° = 23.8%	33° = 11.9%	50° = 0.0%

(4) The following ratings are for dorsiflexion (extension) ankylosis of the metatarsophalangeal joint of the great toe:

Joint Ankylosed at/Percentage of Impairment

0° = 55.0%	17° = 58.1%	34° = 79.2%
1° = 54.4%	18° = 59.4%	35° = 80.5%
2° = 53.8%	19° = 60.7%	36° = 81.8%
3° = 53.2%	20° = 62.0%	37° = 83.1%
4° = 52.6%	21° = 63.2%	38° = 84.4%
5° = 52.0%	22° = 64.4%	39° = 85.7%
6° = 51.4%	23° = 65.6%	40° = 87.0%
7° = 50.8%	24° = 66.8%	41° = 88.3%
8° = 50.2%	25° = 67.0%	42° = 89.6%
9° = 49.6%	26° = 69.2%	43° = 90.9%
10° = 49.0%	27° = 70.4%	44° = 92.2%
11° = 50.3%	28° = 71.6%	45° = 93.5%
12° = 51.6%	29° = 72.8%	46° = 94.8%
13° = 52.9%	30° = 74.0%	47° = 96.1%
14° = 54.2%	31° = 75.3%	48° = 97.4%
15° = 55.5%	32° = 76.6%	49° = 98.7%
16° = 56.8%	33° = 77.9%	50° = 100.0%

(5) The following ratings are for loss of plantar flexion in the metatarsophalangeal joint of the great toe:

Retained Motion/Percentage of Impairment

0° = 21.0%	10° = 14.0%	20° = 7.0%
1° = 20.3%	11° = 13.3%	21° = 6.3%
2° = 19.6%	12° = 12.6%	22° = 5.6%
3° = 18.9%	13° = 11.9%	23° = 4.9%
4° = 18.2%	14° = 11.2%	24° = 4.2%
5° = 17.5%	15° = 10.5%	25° = 3.5%
6° = 16.8%	16° = 9.8%	26° = 2.8%
7° = 16.1%	17° = 9.1%	27° = 2.1%
8° = 15.4%	18° = 8.4%	28° = 1.4%
9° = 14.7%	19° = 7.7%	29° = 0.7%
		30° = 0.0%

(6) The following ratings are for plantarflexion ankylosis of the metatarsophalangeal joint of the great toe:

Joint Ankylosed at/Percentage of Impairment

0° = 55.5%	10° = 70.0%	20° = 85.0%
1° = 56.5%	11° = 71.5%	21° = 86.5%
2° = 58.0%	12° = 73.0%	22° = 88.0%
3° = 59.5%	13° = 74.5%	23° = 89.5%
4° = 61.0%	14° = 76.0%	24° = 91.0%
5° = 62.5%	15° = 77.5%	25° = 92.5%
6° = 64.0%	16° = 79.0%	26° = 94.0%
7° = 65.5%	17° = 80.5%	27° = 95.5%
8° = 67.0%	18° = 82.0%	28° = 97.0%
9° = 68.5%	19° = 83.5%	29° = 98.5%
		30° = 100.0%

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 1-14-03 as WCD Admin. Order 03-050, eff. 2-1-03
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0160 Second Through Fifth Toes

(1) No rating is given for loss of motion in the distal interphalangeal joint of the second through fifth toes (to be referred to as toes), except in the case of ankylosis.

(2) Ankylosis in the distal interphalangeal joint of the toes is rated as follows:

	Toe Impairment
ankylosed in dorsiflexion	45%
ankylosed at 0°	30%
ankylosed in plantarflexion	45%

(3) No rating is given for loss of motion in the proximal interphalangeal joint of the toes, except in the case of ankylosis.

(4) Ankylosis in the proximal interphalangeal joint of the toes is rated as follows:

	Toe Impairment
ankylosed in dorsiflexion	80%
ankylosed at 0°	45%
ankylosed in plantarflexion	80%

(5) The following ratings are for loss of dorsiflexion (extension) in the metatarsophalangeal joints of the toes:

Retained Motion/Percentage of Impairment

0° = 29.0%	14° = 18.2%	28° = 8.4%
1° = 28.2%	15° = 17.5%	29° = 7.7%
2° = 27.4%	16° = 16.8%	30° = 7.0%
3° = 26.6%	17° = 16.1%	31° = 6.3%
4° = 25.8%	18° = 15.4%	32° = 5.6%

5° = 25.0%	19° = 14.7%	33° = 4.9%
6° = 24.2%	20° = 14.0%	34° = 4.2%
7° = 23.4%	21° = 13.3%	35° = 3.5%
8° = 22.6%	22° = 12.6%	36° = 2.8%
9° = 21.8%	23° = 11.9%	37° = 2.1%
10° = 21.0%	24° = 11.2%	38° = 1.4%
11° = 20.3%	25° = 10.5%	39° = 0.7%
12° = 19.6%	26° = 9.8%	40° = 0.0%
13° = 18.9%	27° = 9.1%	

(6) The following ratings are for dorsiflexion (extension) ankylosis in the metatarsophalangeal joints of the toes:

Joint Ankylosed at/Percentage of Impairment

0° = 50.0%	14° = 67.8%	28° = 85.4%
1° = 51.3%	15° = 69.0%	29° = 86.7%
2° = 52.6%	16° = 70.2%	30° = 88.0%
3° = 53.9%	17° = 71.4%	31° = 89.2%
4° = 55.2%	18° = 72.6%	32° = 90.4%
5° = 56.5%	19° = 73.8%	33° = 91.6%
6° = 57.8%	20° = 75.0%	34° = 92.8%
7° = 59.1%	21° = 76.3%	35° = 94.0%
8° = 60.4%	22° = 77.6%	36° = 95.2%
9° = 61.7%	23° = 78.9%	37° = 96.4%
10° = 63.0%	24° = 80.2%	38° = 97.6%
11° = 64.2%	25° = 81.5%	39° = 98.8%
12° = 65.4%	26° = 82.8%	40° = 100.0%
13° = 66.6%	27° = 84.1%	

(7) The following ratings are for loss of (plantar) flexion in the metatarsophalangeal joints of the toes:

Retained Motion/Percentage of Impairment

0° = 21.0%	10° = 14.0%	20° = 7.0%
1° = 20.3%	11° = 13.3%	21° = 6.3%
2° = 19.6%	12° = 12.6%	22° = 5.6%
3° = 18.9%	13° = 11.9%	23° = 4.9%
4° = 18.2%	14° = 11.2%	24° = 4.2%
5° = 17.5%	15° = 10.5%	25° = 3.5%
6° = 16.8%	16° = 9.8%	26° = 2.8%
7° = 16.1%	17° = 9.1%	27° = 2.1%
8° = 15.4%	18° = 8.4%	28° = 1.4%
9° = 14.7%	19° = 7.7%	29° = 0.7%
		30° = 0.0%

(8) Plantarflexion ankylosis in the metatarsophalangeal joints of the toes is rated as follows:

Joint Ankylosed at/Percentage of Impairment

0° = 50.0%	10° = 67.0%	20° = 83.0%
1° = 51.7%	11° = 68.6%	21° = 84.7%
2° = 53.4%	12° = 70.2%	22° = 86.4%
3° = 55.1%	13° = 71.8%	23° = 88.1%
4° = 56.8%	14° = 73.4%	24° = 89.8%
5° = 58.5%	15° = 75.0%	25° = 91.5%
6° = 60.2%	16° = 76.6%	26° = 93.2%
7° = 61.9%	17° = 78.2%	27° = 94.9%
8° = 63.6%	18° = 79.8%	28° = 96.6%
9° = 65.3%	19° = 81.4%	29° = 98.3%
		30° = 100.0%

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 10-26-04 as WCD Admin. Order 04-063, eff 1-1-05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0180 Conversion of Toe Values to Foot Value

(1) If the only findings are in the toes, it is not possible to convert the toe findings to a loss in the foot unless there are impairment findings in the foot. Each toe must be converted to the foot separately. After converting to the foot, each converted value is added.

(2) If there are impairment findings in the foot and impairment findings in the great toe, the following table is used to convert losses in the great toe to losses in the foot:

Great Toe Foot	Great Toe Foot
1- 7% = 1%	51-57% = 8%
8-14% = 2%	58-64% = 9%
15-21% = 3%	65-71% = 10%
22-28% = 4%	72-78% = 11%
29-35% = 5%	79-85% = 12%
36-42% = 6%	86-92% = 13%
43-50% = 7%	93-100% = 14%

(3) If there are impairment findings in the foot and impairment findings in the second through the fifth toes, the following table is used to convert losses in the toes to losses in the foot:

Toe Foot
1-33% = 1%
34-67% = 2%
68-100% = 3%

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 1-8-97 as WCD Admin. Order 96-072, eff. 2-15-97
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0190 Foot

(1) Ankylosis at the tarsometatarsal joints receives a rating of 10% of the foot for each of the tarsometatarsal joints ankylosed.

(2) The following ratings are for loss of subtalar inversion in the foot:

Retained Motion/Percentage of Impairment

0° = 5.0%	10° = 4.0%	20° = 2.0%
1° = 4.9%	11° = 3.8%	21° = 1.8%
2° = 4.8%	12° = 3.6%	22° = 1.6%
3° = 4.7%	13° = 3.4%	23° = 1.4%
4° = 4.6%	14° = 3.2%	24° = 1.2%
5° = 4.5%	15° = 3.0%	25° = 1.0%
6° = 4.4%	16° = 2.8%	26° = 0.8%
7° = 4.3%	17° = 2.6%	27° = 0.6%
8° = 4.2%	18° = 2.4%	28° = 0.4%
9° = 4.1%	19° = 2.2%	29° = 0.2%
		30° = 0.0%

(3) The following ratings are for subtalar inversion (varus) ankylosis in the foot:

Joint Ankylosed at/Percentage of Impairment

0° = 10.0%	10° = 43.0%	20° = 57.0%
1° = 13.3%	11° = 44.4%	21° = 58.3%
2° = 16.6%	12° = 45.8%	22° = 59.6%
3° = 19.9%	13° = 47.2%	23° = 60.9%
4° = 23.2%	14° = 48.6%	24° = 62.2%
5° = 26.5%	15° = 50.0%	25° = 63.5%
6° = 29.8%	16° = 51.4%	26° = 64.8%
7° = 33.1%	17° = 52.8%	27° = 66.1%
8° = 36.4%	18° = 54.2%	28° = 67.4%
9° = 39.7%	19° = 55.6%	29° = 68.7%
		30° = 70.0%

(4) The following ratings are for loss of subtalar eversion in the foot:

Retained Motion/Percentage of Impairment

0° = 4.0%	7° = 2.6%	14° = 1.2%
1° = 3.8%	8° = 2.4%	15° = 1.0%
2° = 3.6%	9° = 2.2%	16° = 0.8%
3° = 3.4%	10° = 2.0%	17° = 0.6%
4° = 3.2%	11° = 1.8%	18° = 0.4%
5° = 3.0%	12° = 1.6%	19° = 0.2%
6° = 2.8%	13° = 1.4%	20° = 0.0%

(5) The following ratings are for subtalar eversion (valgus) ankylosis in the foot:

Joint Ankylosed at/Percentage of Impairment

0° = 10%	7° = 38%	14° = 54%
1° = 14%	8° = 42%	15° = 55%
2° = 18%	9° = 46%	16° = 56%
3° = 22%	10° = 50%	17° = 57%
4° = 26%	11° = 51%	18° = 58%
5° = 30%	12° = 52%	19° = 59%
6° = 34%	13° = 53%	20° = 60%

(6) The following ratings are for loss of dorsiflexion (extension) in the ankle joint:

Retained Motion/Percentage of Impairment

0° = 7.0%	7° = 4.9%	14° = 2.4%
1° = 6.7%	8° = 4.6%	15° = 2.0%
2° = 6.4%	9° = 4.3%	16° = 1.6%
3° = 6.1%	10° = 4.0%	17° = 1.2%
4° = 5.8%	11° = 3.6%	18° = 0.8%
5° = 5.5%	12° = 3.2%	19° = 0.4%
6° = 5.2%	13° = 2.8%	20° = 0.0%

(7) The following ratings are for dorsiflexion (extension) ankylosis in the ankle joint:

Joint Ankylosed at/Percentage of Impairment

0° = 30%	7° = 44%	14° = 58%
1° = 32%	8° = 46%	15° = 60%
2° = 34%	9° = 48%	16° = 62%
3° = 36%	10° = 50%	17° = 64%
4° = 38%	11° = 52%	18° = 66%
5° = 40%	12° = 54%	19° = 68%
6° = 42%	13° = 56%	20° = 70%

(8) The following ratings are for loss of plantarflexion in the ankle joint:

Retained Motion/Percentage of Impairment

0° = 14.0%	14° = 9.4%	28° = 4.6%
1° = 13.7%	15° = 9.0%	29° = 4.3%
2° = 13.4%	16° = 8.6%	30° = 4.0%
3° = 13.1%	17° = 8.2%	31° = 3.6%
4° = 12.8%	18° = 7.8%	32° = 3.2%
5° = 12.5%	19° = 7.4%	33° = 2.8%
6° = 12.2%	20° = 7.0%	34° = 2.4%
7° = 11.9%	21° = 6.7%	35° = 2.0%
8° = 11.6%	22° = 6.4%	36° = 1.6%
9° = 11.3%	23° = 6.1%	37° = 1.2%
10° = 11.0%	24° = 5.8%	38° = 0.8%
11° = 10.6%	25° = 5.5%	39° = 0.4%
12° = 10.2%	26° = 5.2%	40° = 0.0%
13° = 9.8%	27° = 4.9%	

(9) The following ratings are for plantarflexion ankylosis in the ankle joint:

Joint Ankylosed at/Percentage of Impairment

0° = 30%	14° = 44%	28° = 58%
1° = 31%	15° = 45%	29° = 59%
2° = 32%	16° = 46%	30° = 60%
3° = 33%	17° = 47%	31° = 61%
4° = 34%	18° = 48%	32° = 62%
5° = 35%	19° = 49%	33° = 63%
6° = 36%	20° = 50%	34° = 64%
7° = 37%	21° = 51%	35° = 65%
8° = 38%	22° = 52%	36° = 66%
9° = 39%	23° = 53%	37° = 67%
10° = 40%	24° = 54%	38° = 68%
11° = 41%	25° = 55%	39° = 69%
12° = 42%	26° = 56%	40° = 70%
13° = 43%	27° = 57%	

(10) The following applies when determining impairment for loss of motion or ankylosis in the ankle or subtalar joint:

(a) If there is loss of motion only (no ankylosis in either joint) in the subtalar joint or the ankle joint, the following applies:

(A) the values for loss of motion in the subtalar joint are added;

(B) the values for loss of motion in the ankle joint are added;

(C) the value for loss of motion in the subtalar joint is added to the value for loss of motion in the ankle joint.

(b) If there is ankylosis in the ankle or subtalar joint, the following applies:

(A) When there is ankylosis in one joint only with no loss of motion or ankylosis in the other joint, that ankylosis value is granted.

(B) When there is loss of motion in one joint and ankylosis in the other joint, add the ankylosis value to the value for loss of motion in the non-ankylosed joint.

(C) When the ankle joint is ankylosed in plantar flexion and dorsiflexion, use only the largest ankylosis value for rating the loss or only one of the values if they are identical. Under OAR 436-035-0011(10), this ankylosis value is granted in lieu of all other range of motion or ankylosis values for the ankle joint.

(D) When the subtalar joint is ankylosed in inversion and eversion, use only the largest ankylosis value for rating the loss or only one of the values if they are identical. Under OAR 436-035-0011(10), this ankylosis value is granted in lieu of all other range of motion or ankylosis values for the subtalar joint.

(E) When both joints are ankylosed, add the ankle joint value to the subtalar joint value.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 5/5/10 as WCD Admin. Order 10-051, eff. 6/1/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0210 Conversion of Foot Value to Leg Value

(1) The following ratings are for converting losses in the foot to losses in the leg:

Impairment of Foot Leg	Impairment of Foot Leg	Impairment of Foot Leg
1% = 1%	34% = 31%	68% = 61%
2% = 2%	35-36% = 32%	69% = 62%
3% = 3%	37% = 33%	70% = 63%
4% = 4%	38% = 34%	71% = 64%
5-6% = 5%	39% = 35%	72% = 65%
7% = 6%	40% = 36%	73% = 66%
8% = 7%	41% = 37%	74% = 67%
9% = 8%	42% = 38%	75-76% = 68%
10% = 9%	43% = 39%	77% = 69%
11% = 10%	44% = 40%	78% = 70%
12% = 11%	45-46% = 41%	79% = 71%
13% = 12%	47% = 42%	80% = 72%
14% = 13%	48% = 43%	81% = 73%
15-16% = 14%	49% = 44%	82% = 74%
17% = 15%	50% = 45%	83% = 75%
18% = 16%	51% = 46%	84% = 76%
19% = 17%	52% = 47%	85-86% = 77%
20% = 18%	53% = 48%	87% = 78%
21% = 19%	54% = 49%	88% = 79%
22% = 20%	55-56% = 50%	89% = 80%
23% = 21%	57% = 51%	90% = 81%
24% = 22%	58% = 52%	91% = 82%
25-26% = 23%	59% = 53%	92% = 83%
27% = 24%	60% = 54%	93% = 84%
28% = 25%	61% = 55%	94% = 85%
29% = 26%	62% = 56%	95-96% = 86%
30% = 27%	63% = 57%	97% = 87%
31% = 28%	64% = 58%	98% = 88%
32% = 29%	65-66% = 59%	99% = 89%
33% = 30%	67% = 60%	100% = 90%

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 3-26-91 as WCD Admin. Order 2-1991, eff. 4-1-91
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0220 Leg

(1) The following ratings are for loss of flexion in the knee (150° describes the knee in full flexion):

Retained Motion/Percentage of Impairment

0° = 53.0%	38° = 39.6%	76° = 26.2%	114° = 12.8%
1° = 52.6%	39° = 39.3%	77° = 25.9%	115° = 12.5%
2° = 52.2%	40° = 39.0%	78° = 25.6%	116° = 12.2%
3° = 51.8%	41° = 38.6%	79° = 25.3%	117° = 11.9%
4° = 51.4%	42° = 38.2%	80° = 25.0%	118° = 11.6%
5° = 51.0%	43° = 37.8%	81° = 24.6%	119° = 11.3%
6° = 50.6%	44° = 37.4%	82° = 24.2%	120° = 11.0%
7° = 50.2%	45° = 37.0%	83° = 23.8%	121° = 10.6%
8° = 49.8%	46° = 36.6%	84° = 23.4%	122° = 10.2%
9° = 49.4%	47° = 36.2%	85° = 23.0%	123° = 9.8%
10° = 49.0%	48° = 35.8%	86° = 22.6%	124° = 9.4%
11° = 48.7%	49° = 35.4%	87° = 22.2%	125° = 9.0%
12° = 48.4%	50° = 35.0%	88° = 21.8%	126° = 8.6%
13° = 48.1%	51° = 34.7%	89° = 21.4%	127° = 8.2%
14° = 47.8%	52° = 34.4%	90° = 21.0%	128° = 7.8%
15° = 47.5%	53° = 34.1%	91° = 20.7%	129° = 7.4%
16° = 47.2%	54° = 33.8%	92° = 20.4%	130° = 7.0%
17° = 46.9%	55° = 33.5%	93° = 20.1%	131° = 6.7%
18° = 46.6%	56° = 33.2%	94° = 19.8%	132° = 6.4%
19° = 46.3%	57° = 32.9%	95° = 19.5%	133° = 6.1%
20° = 46.0%	58° = 32.6%	96° = 19.2%	134° = 5.8%
21° = 45.6%	59° = 32.3%	97° = 18.9%	135° = 5.5%
22° = 45.2%	60° = 32.0%	98° = 18.6%	136° = 5.2%
23° = 44.8%	61° = 31.6%	99° = 18.3%	137° = 4.9%
24° = 44.4%	62° = 31.2%	100° = 18.0%	138° = 4.6%
25° = 44.0%	63° = 30.8%	101° = 17.6%	139° = 4.3%
26° = 43.6%	64° = 30.4%	102° = 17.2%	140° = 4.0%
27° = 43.2%	65° = 30.0%	103° = 16.8%	141° = 3.6%
28° = 42.8%	66° = 29.6%	104° = 16.4%	142° = 3.2%
29° = 42.4%	67° = 29.2%	105° = 16.0%	143° = 2.8%
30° = 42.0%	68° = 28.8%	106° = 15.6%	144° = 2.4%
31° = 41.7%	69° = 28.4%	107° = 15.2%	145° = 2.0%
32° = 41.4%	70° = 28.0%	108° = 14.8%	146° = 1.6%
33° = 41.1%	71° = 27.7%	109° = 14.4%	147° = 1.2%
34° = 40.8%	72° = 27.4%	110° = 14.0%	148° = 0.8%
35° = 40.5%	73° = 27.1%	111° = 13.7%	149° = 0.4%
36° = 40.2%	74° = 26.8%	112° = 13.4%	150° = 0.0%
37° = 39.9%	75° = 26.5%	113° = 13.1%	

(2) The following ratings are for loss of extension in the knee (0° describes the knee in full extension):

Retained Motion/Percentage of Impairment

0° = 0.0%	17° = 5.2%	34° = 21.0%
1° = 0.1%	18° = 5.8%	35° = 22.0%
2° = 0.2%	19° = 6.4%	36° = 23.0%
3° = 0.3%	20° = 7.0%	37° = 24.0%
4° = 0.4%	21° = 8.0%	38° = 25.0%
5° = 0.5%	22° = 9.0%	39° = 26.0%
6° = 0.6%	23° = 10.0%	40° = 27.0%
7° = 0.7%	24° = 11.0%	41° = 33.3%

8° = 0.8%	25° = 12.0%	42° = 39.6%
9° = 0.9%	26° = 13.0%	43° = 45.9%
10° = 1.0%	27° = 14.0%	44° = 52.2%
11° = 1.6%	28° = 15.0%	45° = 58.5%
12° = 2.2%	29° = 16.0%	46° = 64.8%
13° = 2.8%	30° = 17.0%	47° = 71.1%
14° = 3.4%	31° = 18.0%	48° = 77.4%
15° = 4.0%	32° = 19.0%	49° = 83.7%
16° = 4.6%	33° = 20.0%	50 -150° = 90.0%

(3) Ankylosis of the knee in flexion or extension is rated as follows:

Joint Ankylosed at/Percentage of Impairment

0° = 53.0%	17° = 57%	34° = 74%
1° = 52.7%	18° = 58%	35° = 75%
2° = 52.4%	19° = 59%	36° = 76%
3° = 52.1%	20° = 60%	37° = 77%
4° = 51.8%	21° = 61%	38° = 78%
5° = 51.5%	22° = 62%	39° = 79%
6° = 51.2%	23° = 63%	40° = 80%
7° = 50.9%	24° = 64%	41° = 81%
8° = 50.6%	25° = 65%	42° = 82%
9° = 50.3%	26° = 66%	43° = 83%
10° = 50.0%	27° = 67%	44° = 84%
11° = 51.0%	28° = 68%	45° = 85%
12° = 52.0%	29° = 69%	46° = 86%
13° = 53%	30° = 70%	47° = 87%
14° = 54%	31° = 71%	48° = 88%
15° = 55%	32° = 72%	49° = 89%
16° = 56%	33° = 73%	50-150° = 90%

(4) The determination of loss of range of motion in the hip is valued in this section when there is no pelvic bone involvement. Loss associated with pelvic bone involvement is determined under OAR 436-035-0340.

(5) The following ratings are for loss of forward flexion in the hip:

Retained Motion/Percentage of Impairment

0° = 18.0%	34° = 11.6%	68° = 5.4%
1° = 17.8%	35° = 11.5%	69° = 5.2%
2° = 17.6%	36° = 11.4%	70° = 5.0%
3° = 17.4%	37° = 11.3%	71° = 4.9%
4° = 17.2%	38° = 11.2%	72° = 4.8%
5° = 17.0%	39° = 11.1%	73° = 4.7%
6° = 16.8%	40° = 11.0%	74° = 4.6%
7° = 16.6%	41° = 10.8%	75° = 4.5%
8° = 16.4%	42° = 10.6%	76° = 4.4%
9° = 16.2%	43° = 10.4%	77° = 4.3%
10° = 16.0%	44° = 10.2%	78° = 4.2%
11° = 15.8%	45° = 10.0%	79° = 4.1%
12° = 15.6%	46° = 9.8%	80° = 4.0%
13° = 15.4%	47° = 9.6%	81° = 3.8%
14° = 15.2%	48° = 9.4%	82° = 3.6%
15° = 15.0%	49° = 9.2%	83° = 3.4%
16° = 14.8%	50° = 9.0%	84° = 3.2%
17° = 14.6%	51° = 8.8%	85° = 3.0%
18° = 14.4%	52° = 8.6%	86° = 2.8%
19° = 14.2%	53° = 8.4%	87° = 2.6%
20° = 14.0%	54° = 8.2%	88° = 2.4%
21° = 13.8%	55° = 8.0%	89° = 2.2%
22° = 13.6%	56° = 7.8%	90° = 2.0%
23° = 13.4%	57° = 7.6%	91° = 1.8%
24° = 13.2%	58° = 7.4%	92° = 1.6%
25° = 13.0%	59° = 7.2%	93° = 1.4%
26° = 12.8%	60° = 7.0%	94° = 1.2%
27° = 12.6%	61° = 6.8%	95° = 1.0%
28° = 12.4%	62° = 6.6%	96° = 0.8%
29° = 12.2%	63° = 6.4%	97° = 0.6%
30° = 12.0%	64° = 6.2%	98° = 0.4%
31° = 11.9%	65° = 6.0%	99° = 0.2%
32° = 11.8%	66° = 5.8%	100° = 0.0%
33° = 11.7%	67° = 5.6%	

(6) The following ratings are for loss of backward extension in the hip joint:

Retained Motion/Percentage of Impairment

0° = 5.0%	10° = 4.0%	20° = 2.0%
1° = 4.9%	11° = 3.8%	21° = 1.8%
2° = 4.8%	12° = 3.6%	22° = 1.6%
3° = 4.7%	13° = 3.4%	23° = 1.4%
4° = 4.6%	14° = 3.2%	24° = 1.2%
5° = 4.5%	15° = 3.0%	25° = 1.0%
6° = 4.4%	16° = 2.8%	26° = 0.8%
7° = 4.3%	17° = 2.6%	27° = 0.6%
8° = 4.2%	18° = 2.4%	28° = 0.4%
9° = 4.1%	19° = 2.2%	29° = 0.2%
		30° = 0.0%

(7) The following ratings are for loss of abduction in the hip joint:

Retained Motion/Percentage of Impairment

0° = 16.0%	14° = 10.4%	28° = 4.8%
1° = 15.6%	15° = 10.0%	29° = 4.4%
2° = 15.2%	16° = 9.6%	30° = 4.0%
3° = 14.8%	17° = 9.2%	31° = 3.6%
4° = 14.4%	18° = 8.8%	32° = 3.2%
5° = 14.0%	19° = 8.4%	33° = 2.8%
6° = 13.6%	20° = 8.0%	34° = 2.4%
7° = 13.2%	21° = 7.6%	35° = 2.0%
8° = 12.8%	22° = 7.2%	36° = 1.6%
9° = 12.4%	23° = 6.8%	37° = 1.2%
10° = 12.0%	24° = 6.4%	38° = 0.8%
11° = 11.6%	25° = 6.0%	39° = 0.4%
12° = 11.2%	26° = 5.6%	40° = 0.0%
13° = 10.8%	27° = 5.2%	

(8) The following ratings are for loss of adduction in the hip joint:

Retained Motion/Percentage of Impairment

0° = 8.0%	7° = 5.2%	14° = 2.4%
1° = 7.6%	8° = 4.8%	15° = 2.0%
2° = 7.2%	9° = 4.4%	16° = 1.6%
3° = 6.8%	10° = 4.0%	17° = 1.2%
4° = 6.4%	11° = 3.6%	18° = 0.8%
5° = 6.0%	12° = 3.2%	19° = 0.4%
6° = 5.6%	13° = 2.8%	20° = 0.0%

(9) The following ratings are for loss of internal rotation in the hip joint:

Retained Motion/Percentage of Impairment

0° = 10.0%	14° = 6.8%	28° = 3.4%
1° = 9.8%	15° = 6.5%	29° = 3.2%
2° = 9.6%	16° = 6.2%	30° = 3.0%
3° = 9.4%	17° = 5.9%	31° = 2.7%
4° = 9.2%	18° = 5.6%	32° = 2.4%
5° = 9.0%	19° = 5.3%	33° = 2.1%
6° = 8.8%	20° = 5.0%	34° = 1.8%
7° = 8.6%	21° = 4.8%	35° = 1.5%
8° = 8.4%	22° = 4.6%	36° = 1.2%
9° = 8.2%	23° = 4.4%	37° = 0.9%
10° = 8.0%	24° = 4.2%	38° = 0.6%
11° = 7.7%	25° = 4.0%	39° = 0.3%
12° = 7.4%	26° = 3.8%	40° = 0.0%
13° = 7.1%	27° = 3.6%	

(10) The following ratings are for loss of external rotation in the hip joint:

Retained Motion/Percentage of Impairment

0° = 13.0%	17° = 8.6%	34° = 4.2%
1° = 12.7%	18° = 8.4%	35° = 4.0%
2° = 12.4%	19° = 8.2%	36° = 3.8%
3° = 12.1%	20° = 8.0%	37° = 3.6%
4° = 11.8%	21° = 7.7%	38° = 3.4%
5° = 11.5%	22° = 7.4%	39° = 3.2%
6° = 11.2%	23° = 7.1%	40° = 3.0%
7° = 10.9%	24° = 6.8%	41° = 2.7%
8° = 10.6%	25° = 6.5%	42° = 2.4%
9° = 10.3%	26° = 6.2%	43° = 2.1%
10° = 10.0%	27° = 5.9%	44° = 1.8%
11° = 9.8%	28° = 5.6%	45° = 1.5%
12° = 9.6%	29° = 5.3%	46° = 1.2%
13° = 9.4%	30° = 5.0%	47° = 0.9%
14° = 9.2%	31° = 4.8%	48° = 0.6%
15° = 9.0%	32° = 4.6%	49° = 0.3%
16° = 8.8%	33° = 4.4%	50° = 0.0%

(11) Ankylosis in the hip joint is rated under OAR 436-035-0340.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 10-26-04 as WCD Admin. Order 04-063, eff 1-1-05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0230 Other Lower Extremity Findings

(1) Loss of sensation or hypersensitivity in the leg is not considered disabling except for the plantar surface of the foot and toes, including the great toe, where it is rated as follows:

(a)	Toe (in any toe)	Foot
partial loss of sensation or hypersensitivity	5%	5%
total loss of sensation or hypersensitivity	10%	10%

(b) Partial is part of the toe or foot. Total means the entire toe or foot.

(c) Loss of sensation or hypersensitivity in the toes in addition to loss of sensation or hypersensitivity in the foot is rated for the foot only. No additional value is allowed for loss of sensation or hypersensitivity in the toes.

(d) When there are hypersensitivity and sensation loss, both conditions are rated.

(2) The following ratings are for length discrepancies of the injured leg. However, loss of length due to flexion/extension deformities is excluded. The rating is the same whether the length change is a result of an injury to the foot or to the upper leg:

Discrepancy in inches	**Leg**
1/4 to 1/2 inch	5%
More than 1/2 inch up to and including 1 inch	10%
More than 1 inch up to and including 1-1/2 inches	15%
More than 1-1/2 inches	20%

(3) Valid instability in the ankle or knee substantiated by clinical findings is valued based on the ligament demonstrating the laxity, as described in the table below. The instability value is given even if the ligament itself has not been injured.

	Mild		Moderate		Severe	
Ligament	Ankle	Leg	Ankle	Leg	Ankle	Leg
Collateral (medial)	6%	10%	11%	15%	17%	20%
Collateral (lateral)	9%	10%	18%	15%	28%	20%
Anterior cruciate		5%		10%		15%
Posterior cruciate		5%		10%		15%

(a) For ankle joint instability to be rated as severe there must be a complete disruption of two or more ligaments. Following are examples of ankle ligaments that may contribute to joint instability:

(A) The lateral collateral ligaments including the anterior talofibular, calcaneofibular, talocalcaneal, posterior talocalcaneal, and the posterior talofibular.

(B) The medial collateral ligaments, or deltoid ligament, including the tibionavicular, calcaneotibial, anterior talotibial, and the posterior talotibial.

(b) For knee joint instability the severity of joint opening is mild at a grade 1 or 1+ (1-5mm), moderate at a grade 2 or 2+ (6-10mm), and severe at a grade 3 or 3+ (>10mm).

(c) Ankle joint instability with additional anterior or posterior instability receives an additional 10%.

(d) When there is a prosthetic knee replacement, instability of the knee is not rated unless the severity of the instability is equivalent to Grade 2 or greater.

(e) Rotary instability in the knee is included in the impairment value(s) of this section.

(f) Multiple instability values in a single joint are combined.

(4) When injury in the ankle or knee/leg results in angulation or malalignment, impairment values are determined under the following:

(a) Varus deformity greater than 15° of the knee/leg is rated at 10% of the leg and of the ankle is rated at 10% of the foot.

(b) Valgus deformity greater than 20° of the knee/leg is rated at 10% of the leg and of the ankle is rated at 10% of the foot.

(c) Tibial shaft fracture resulting in angulation or malalignment (rotational deformity) affects the function of the entire leg and is rated as follows:

Severity	**Leg impairment**
Mild: 10°– 14°	17%
Moderate: 15°– 19°	26%
Severe: 20°+	26% plus 1% for each additional degree, to 43% maximum

(d) Injury resulting in a rocker bottom deformity of the foot is valued at 14%.

(5) The following values are for surgery of the toes, foot, or leg:

(a)	**In the great toe:**	**Toe impairment**
	interphalangeal joint arthroplasty or resection	20%
	metatarsophalangeal joint arthroplasty or resection	30%
(b)	**In the second through fifth toes:**	**Toe impairment**
	distal interphalangeal joint arthroplasty or resection	15%
	proximal interphalangeal joint arthroplasty or resection	25%
	metatarsophalangeal joint arthroplasty or resection	25%
(c)	**Foot surgery**	**Foot/ankle impairment**
	Resection of any part of a metatarsal	10%
	Ankylosed tarsometatarsal joint	10%
	Prosthetic ankle replacement	25%
(d)	**Leg surgery**	**Leg impairment**
	Less than complete loss of one meniscus (no additional value is allowed for multiple partial resections of a single meniscus)	5%
	Complete loss of one meniscus	10%
	Complete loss of one meniscus with less than complete loss of the other	15%
	Complete loss of both menisci	25%
	Each 1/4 of patella removed	5%
	Prosthetic femoral head replacement	15%
	Total or partial prosthetic knee replacement (no additional value is allowed for multiple, partial or total, replacements).	20%

(e) When rating a prosthetic knee replacement, a separate value for meniscectomy(s) or patellectomy for the same knee is not granted.

(f) A meniscectomy is rated as a complete loss unless the record indicates that more than the rim of the meniscus remains.

(6) Dermatological conditions including burns which are limited to the leg, foot, or toes are rated based on the body part affected. The percentages indicated in the classes below are applied to the affected body part(s), e.g., a Class 1 dermatological condition of the foot is 3% of the foot, or a Class 1 dermatological condition of the leg is 3% of the leg. Contact dermatitis is determined under this section unless it is caused by an allergic systemic reaction which is also determined under OAR 436-035-0450. Contact dermatitis for a body part other than the upper or lower extremities is rated under OAR 436-035-0440. Impairments may or may not show

signs or symptoms of skin disorder upon examination but are rated according to the following classes:

(a) **Class 1**: 3% for the leg, foot, or toe if treatment results in no more than minimal limitations in the performance of the activities of daily living (ADL), although exposure to physical or chemical agents may temporarily increase limitations.

(b) **Class 2**: 15% for the leg, foot, or toe if intermittent treatments and prescribed examinations are required, and the worker has some limitations in the performance of ADL.

(c) **Class 3**: 38% for the leg, foot, or toe if regularly prescribed examinations and continuous treatments are required, and the worker has many limitations in the performance of ADL.

(d) **Class 4**: 68% for the leg, foot, or toe if continuous prescribed treatments are required. The treatment may include periodically having the worker stay home or admitting the worker to a care facility, and the worker has many limitations in the performance of ADL.

(e) **Class 5**: 90% for the leg, foot, or toe if continuous prescribed treatment is required. The treatment necessitates having the worker stay home or permanently admitting the worker to a care facility, and the worker has severe limitations in the performance of ADL.

(f) Full thickness skin loss of the heel is valued at 10% of the foot, even when the area is successfully covered with an appropriate skin graft.

(7) The following ratings are for vascular dysfunction of the leg. The impairment values are determined according to the following classifications:

(a) **Class 1**: 3% when any of the following exist:

(A) Loss of pulses in the foot.

(B) Minimal loss of subcutaneous tissue.

(C) Calcification of the arteries (as revealed by x-ray).

(D) Transient edema.

(b) **Class 2**: 15% when any of the following exist:

(A) Limping due to intermittent claudication that occurs when walking at least 100 yards.

(B) Vascular damage, as evidenced by a healed painless stump of a single amputated toe, with evidence of chronic vascular dysfunction or a healed ulcer.

(C) Persistent moderate edema which is only partially controlled by support hose.

(c) **Class 3**: 35% when any of the following exist:

(A) Limping due to intermittent claudication when walking as little as 25 yards and no more than 100 yards.

(B) Vascular damage, as evidenced by healed amputation stumps of two or more toes on one foot, with evidence of chronic vascular dysfunction or persistent superficial ulcers on one leg.

(C) Obvious severe edema which is only partially controlled by support hose.

(d) **Class 4**: 63% when any of the following exist:

(A) Limping due to intermittent claudication after walking less than 25 yards.

(B) Intermittent pain in the legs due to intermittent claudication when at rest.

(C) Vascular damage, as evidenced by amputation at or above the ankle on one leg, or amputation of two or more toes on both feet, with evidence of chronic vascular dysfunction or widespread or deep ulcers on one leg.

(D) Obvious severe edema which cannot be controlled with support hose.

(e) **Class 5**: 88% when either of the following exists:

(A) Constant severe pain due to claudication at rest.

(B) Vascular damage, as evidenced by amputations at or above the ankles of both legs, or amputation of all toes on both feet, with evidence of persistent vascular dysfunction or of persistent, widespread, or deep ulcerations on both legs.

(f) If partial amputation of the lower extremity occurs as a result of vascular dysfunction, the impairment values are rated separately. The amputation value is then combined with the impairment value for the vascular dysfunction.

(8) Injuries to unilateral spinal nerve roots with resultant loss of strength in the leg or foot are rated based on the specific nerve root supplying (innervating) the weakened muscle(s), as described in the following table and modified under OAR 436-035-0011(7).

(a)	**Spinal nerve root**	**Leg impairment**
	L-2	20%
	L-3	20%
	L-4	34%
	L-5	37%
	S-1	20%

(b) Loss of strength in bilateral extremities results in each extremity being rated separately.

(9) When a spinal nerve root or lumbosacral plexus are not injured, valid loss of strength in the leg or foot is valued as if the peripheral nerve supplying (innervating) the muscle(s) demonstrating the decreased strength was impaired, as described in the following table and as modified under OAR 436-035-0011(7).

		Foot impairment
Common peroneal		39%
	deep (above mid-shin)	28%
	deep (below mid-shin)	6%
	superficial	11%
Tibial nerve		
	posterior tibial (mid-calf & knee)	28%
	below mid-calf	17%
	lateral plantar branch	6%
	medial plantar branch	6%
Peripheral nerve		**Leg impairment**
	Femoral (Below the iliacus nerve)	30%
	Nerves to obturator internus & piriformis	10%
	Nerves to quadratus femoris muscle/nerve to superior gemellus muscle/obturator	10%
	Superior gluteal	20%
	Inferior gluteal	25%
	Sciatic (above hamstring innervation)	75%
	Sciatic (hamstring loss only)	40%
	Tibial nerve (medial popliteal or internal popliteal above knee)	35%

Example 1: A worker suffers a knee injury requiring surgery. Upon recovery, the attending physician reports 4/5 strength of the quadriceps femoris. The quadriceps femoris is innervated by the femoral nerve which has a 30% impairment value. 4/5 strength, under OAR 436-035-0011(7), is 20%. Final impairment is determined by multiplying 30% by 20% for a final value of 6% impairment of the leg.

Example 2: A worker suffers a laceration of the deep branch of the common peroneal nerve above mid-shin. Upon recovery, the attending physician reports 3/5 strength of the calf. The deep common peroneal above mid-shin has a 28% impairment value. Under OAR 436-035-0011(7), 3/5 strength is 50%. Impairment is determined by multiplying 28% by 50% for a final value of 14% impairment of the foot.

(a) Loss of strength due to an injury in a single toe receives a value of zero, unless the strength loss is due to a compensable condition that is proximal to the digit.

(b) Decreased strength due to an amputation receives no rating for weakness in addition to that given for the amputation.

(c) Decreased strength due to a loss in range of motion receives no rating for weakness in addition to that given for the loss of range of motion.

(10) For motor loss to any part of a leg which is due to brain or spinal cord damage, impairment is valued as follows:

(a) **Class 1**: 23% when the worker can rise to a standing position and can walk but has difficulty with elevations, grades, steps, and distances.

(b) **Class 2**: 48% when the worker can rise to a standing position and can walk with difficulty but is limited to level surfaces. There is variability as to the distance the worker can walk.

(c) **Class 3**: 76% when the worker can rise to a standing position and can maintain it with difficulty but cannot walk without assistance.

(d) **Class 4**: 100% when the worker cannot stand without a prosthesis, the help of others, or mechanical support.

(e) When a value is granted under this section, additional impairment values in the same extremity are not allowed for strength loss, chronic condition, reduced range of motion, or limited ability to walk/stand for two hours or less because they have been included in the impairment values shown in this section.

(f) For bilateral extremity loss, each extremity is rated separately.

(11) If there is a diagnosis of Grade IV chondromalacia, extensive arthritis or extensive degenerative joint disease and one or more of the following are present: secondary strength loss; chronic effusion; varus or valgus deformity less than that specified in section (4) of this rule, then one or more of the following rating values apply:

(a) 5% of the foot for the ankle joint; or

(b) 5% of the leg for the knee joint.

(12) For a diagnosis of degenerative joint disease, chondromalacia, or arthritis which does not meet the criteria noted in section (11) of this rule, the impairment is determined under the chronic condition rule (OAR 436-035-0019) if the criteria in that rule is met.

(13) Other impairment values, e.g., weakness, chronic condition, reduced range of motion, etc., are combined with the value granted in section (11) of this rule.

(14) When the worker cannot be on his or her feet for more than two hours in an 8-hour period, the award is 15% of the leg.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0235 Conversion of Lower Extremity Values to Whole Person Values

(1) The tables in this rule are used to convert losses in the lower extremity to a whole person (WP) value for claims with a date of injury on or after January 1, 2005.

(2) The following table is used to convert losses in the great toe to a whole person (WP) value. Impairment in any of the other toes receives a whole person value of 1% for each toe that is injured.

Great Toe	WP	Great Toe	WP
1-24%	= 1%	59-74%	= 4%
25-41%	= 2%	75-91%	= 5%
42-58%	= 3%	92-100%	= 6%

(3) The following table is used to convert a loss in the foot to a whole person (WP) value.

Foot	WP	Foot	WP	Foot	WP
1-3%	= 1%	35-36%	= 15%	68-70%	= 29%
4-5%	= 2%	37-39%	= 16%	71-72%	= 30%
6-8%	= 3%	40-41%	= 17%	73-74%	= 31%
9-10%	= 4%	42-44%	= 18%	75-77%	= 32%
11-13%	= 5%	45-46%	= 19%	78-79%	= 33%
14-15%	= 6%	47-48%	= 20%	80-82%	= 34%
16-17%	= 7%	49-51%	= 21%	83-84%	= 35%
18-20%	= 8%	52-53%	= 22%	85-86%	= 36%
21-22%	= 9%	54-55%	= 23%	87-89%	= 37%
23-24%	= 10%	56-58%	= 24%	90-91%	= 38%
25-27%	= 11%	59-60%	= 25%	92-94%	= 39%
28-29%	= 12%	61-63%	= 26%	95-96%	= 40%
30-32%	= 13%	64-65%	= 27%	97-98%	= 41%
33-34%	= 14%	66-67%	= 28%	99-100%	= 42%

(4) The following table is used to convert a loss in the leg to a whole person (WP) value.

Leg	WP	Leg	WP	Leg	WP
1-3%	= 1%	36-37%	= 17%	70-71%	= 33%
4-5%	= 2%	38-39%	= 18%	72-73%	= 34%
6-7%	= 3%	40-41%	= 19%	74-75%	= 35%
8-9%	= 4%	42-43%	= 20%	76-77%	= 36%
10-11%	= 5%	44-45%	= 21%	78-79%	= 37%
12-13%	= 6%	46-47%	= 22%	80-81%	= 38%
14-15%	= 7%	48-49%	= 23%	82-84%	= 39%
16-18%	= 8%	50-52%	= 24%	85-86%	= 40%
19-20%	= 9%	53-54%	= 25%	87-88%	= 41%
21-22%	= 10%	55-56%	= 26%	89-90%	= 42%
23-24%	= 11%	57-58%	= 27%	91-92%	= 43%
25-26%	= 12%	59-60%	= 28%	93-94%	= 44%
27-28%	= 13%	61-62%	= 29%	95-96%	= 45%
29-30%	= 14%	63-64%	= 30%	97-98%	= 46%
31-32%	= 15%	65-67%	= 31%	99-100%	= 47%
33-35%	= 16%	68-69%	= 32%		

Stat. Auth.: ORS 656.726; Stats. Implemented: ORS 656.214
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0250 Hearing Loss

(1) The following information is provided by the attending physician or reviewed and commented on by the attending physician, under OAR 436-035-0007(5) and (6), to value work-related hearing loss:

(a) A written record, history, examination, diagnosis, opinion, interpretation and a statement noting if further material improvement would reasonably be expected from medical treatment or the passage of time by a medical provider with specialty training or experience in evaluating hearing loss.

(b) The complete audiometric testing.

(2) A worker is eligible for an award for impairment for any loss of normal hearing that results from the compensable injury. Any hearing loss that existed before the compensable injury and that does not result from a compensable preexisting condition must be offset against hearing loss in the claim if the hearing loss that existed before the compensable injury is adequately documented by a baseline audiogram that was obtained within 180 days of assignment to a high noise environment.

(a) The offset will be done at the monaural percentage of impairment level.

(b) Determine the monaural percentage of impairment for the baseline audiogram under section (4) of this rule.

(c) Subtract the baseline audiogram impairment from the current audiogram impairment to obtain the impairment value.

(3) Hearing loss is based on audiograms which must report on air conduction frequencies at 500, 1,000, 2,000, 3,000, 4,000 and 6,000 Hz.

(a) Audiograms should be based on American National Standards Institute S3.6 (1989) standards.

(b) Test results will be accepted only if they come from a test conducted at least 14 consecutive hours after the worker has been removed from significant exposure to noise.

(4) Impairment of hearing is calculated from the number of decibels by which the worker's hearing exceeds 150 decibels (hearing impairment threshold). Compensation for monaural hearing loss is calculated as follows:

(a) Add the audiogram findings at 500, 1,000, 2,000, 3,000, 4,000 and 6,000 Hz. Decibel readings in excess of 100 will be entered into the computations as 100 dB.

(b) Hearing loss caused by presbycusis is based on the worker's age at the time of the audiogram, except that, in an injury claim, an impairment award for hearing loss caused by presbycusis is reduced only if the presbycusis qualifies as a preexisting condition.

To determine the reduction to be applied for hearing loss caused by presbycusis, consult the Presbycusis Correction Values Table below. (These values represent the total decibels of hearing loss in the six standard frequencies which normally results from aging.) Find the figure for presbycusis hearing loss. Take this presbycusis figure and subtract the hearing impairment threshold of 150 decibels. Subtract any positive value from the sum of the audiogram entries. This value represents the total decibels of hearing loss in the six standard frequencies which normally results from aging that exceed the hearing impairment threshold. (If there is no positive value there is no hearing impairment attributable to presbycusis above the hearing impairment threshold.)

AGE -----MEN ----WOMEN
20 or younger ---0 ----------0
21 ----------1 ----------0
22 ----------1 ----------1
23 ----------2 ----------1
24 ----------2 ----------2
25 ----------3 ----------2
26 ----------4 ----------3
27 ----------5 ----------3
28 ----------6 ----------4
29 ----------7 ----------5
30 ----------9 ----------6
31 ----------10 ----------7
32 ----------12 ----------8
33 ----------14 ----------9
34 ----------15 ----------11
35 ----------17 ----------12
36 ----------19 ----------14
37 ----------22 ----------15
38 ----------24 ----------17
39 ----------26 ----------19
40 ----------29 ----------20
41 ----------32 ----------22
42 ----------35 ----------24
43 ----------38 ----------26
44 ----------41 ----------28
45 ----------44 ----------31
46 ----------47 ----------33
47 ----------50 ----------35
48 ----------54 ----------38
49 ----------58 ----------40
50 ----------61 ----------43
51 ----------65 ----------46
52 ----------69 ----------49

AGE ------MEN ---WOMEN
53 ----------74 ----------51
54 ----------78 ----------54
55 ----------82 ----------57
56 ----------87 ----------61
57 ----------91 ----------64
58 ----------96 ----------67
59 ----------101 ----------71
60 ----------106 ----------74
61 ----------111 ----------78
62 ----------116 ----------81
63 ----------122 ----------85
64 ----------127 ----------89
65 ----------133 ----------93
66 ----------138 ----------97
67 ----------144 ----------101
68 ---------- 150 ----------105
69 ----------156 ----------109
70 ----------162 ----------114
71 ----------169 ----------118
72 ----------175 ----------122
73 ----------182 ----------127
74 ----------188 ----------132
75 ----------195 ----------136
76 ----------202 ----------141
77 ----------209 ----------146
78 ----------216 ----------151
79 ----------223 ----------156
80 ----------231 ----------161
81 ----------238 ----------167
82 ----------246 ----------172
83 ----------254 ----------177
84 ----------261 ----------183
85 or older --269 ---------189

(c) Consult the Monaural Hearing Loss Table below, using the figure found in subsection (b) of this section. This table will give you the percent of monaural hearing loss to be compensated.

db	%LOSS	db	%LOSS
150.00	0.00	201.00	12.75
151.00	0.25	202.00	13.00
152.00	0.50	203.00	13.25
153.00	0.75	204.00	13.50
154.00	1.00	205.00	13.75
155.00	1.25	206.00	14.00
156.00	1.50	207.00	14.25
157.00	1.75	208.00	14.50
158.00	2.00	209.00	14.75
159.00	2.25	210.00	15.00
160.00	2.50	211.00	15.25
161.00	2.75	212.00	15.50
162.00	3.00	213.00	15.75
163.00	3.25	214.00	16.00
164.00	3.50	215.00	16.25
165.00	3.75	216.00	16.50
166.00	4.00	217.00	16.75
167.00	4.25	218.00	17.00
168.00	4.50	219.00	17.25
169.00	4.75	220.00	17.50
170.00	5.00	221.00	17.75
171.00	5.25	222.00	18.00
172.00	5.50	223.00	18.25
173.00	5.75	224.00	18.50
174.00	6.00	225.00	18.75
175.00	6.25	226.00	19.00
176.00	6.50	227.00	19.25
177.00	6.75	228.00	19.50
178.00	7.00	229.00	19.75
179.00	7.25	230.00	20.00
180.00	7.50	231.00	20.25
181.00	7.75	232.00	20.50
182.00	8.00	233.00	20.75
183.00	8.25	234.00	21.00
184.00	8.50	235.00	21.25
185.00	8.75	236.00	21.50
186.00	9.00	237.00	21.75
187.00	9.25	238.00	22.00
188.00	9.50	239.00	22.25
189.00	9.75	240.00	22.50
190.00	10.00	241.00	22.75
191.00	10.25	242.00	23.00
192.00	10.50	243.00	23.25
193.00	10.75	244.00	23.50
194.00	11.00	245.00	23.75
195.00	11.25	246.00	24.00
196.00	11.50	247.00	24.25
197.00	11.75	248.00	24.50
198.00	12.00	249.00	24.75

db	%LOSS	db	%LOSS
199.00	12.25	250.00	25.00
200.00	12.50	251.00	25.25
252.00	25.50	303.00	38.25
253.00	25.75	304.00	38.50
254.00	26.00	305.00	38.75
255.00	26.25	306.00	39.00
256.00	26.50	307.00	39.25
257.00	26.75	308.00	39.50
258.00	27.00	309.00	39.75
259.00	27.25	310.00	40.00
260.00	27.50	311.00	40.25
261.00	27.75	312.00	40.50
262.00	28.00	313.00	40.75
263.00	28.25	314.00	41.00
264.00	28.50	315.00	41.25
265.00	28.75	316.00	41.50
266.00	29.00	317.00	41.75
267.00	29.25	318.00	42.00
268.00	29.50	319.00	42.25
269.00	29.75	320.00	42.50
270.00	30.00	321.00	42.75
271.00	30.25	322.00	43.00
272.00	30.50	323.00	43.25
273.00	30.75	324.00	43.50
274.00	31.00	325.00	43.75
275.00	31.25	326.00	44.00
276.00	31.50	327.00	44.25
277.00	31.75	328.00	44.50
278.00	32.00	329.00	44.75
279.00	32.25	330.00	45.00
280.00	32.50	331.00	45.25
281.00	32.75	332.00	45.50
282.00	33.00	333.00	45.75
283.00	33.25	334.00	46.00
284.00	33.50	335.00	46.25
285.00	33.75	336.00	46.50
286.00	34.00	337.00	46.75
287.00	34.25	338.00	47.00
288.00	34.50	339.00	47.25
289.00	34.75	340.00	47.50
290.00	35.00	341.00	47.75
291.00	35.25	342.00	48.00
292.00	35.50	343.00	48.25
293.00	35.75	344.00	48.50
294.00	36.00	345.00	48.75
295.00	36.25	346.00	49.00
296.00	36.50	347.00	49.25
297.00	36.75	348.00	49.50
298.00	37.00	349.00	49.75
299.00	37.25	350.00	50.00
300.00	37.50	351.00	50.25
301.00	37.75	352.00	50.50
302.00	38.00	353.00	50.75

db	%LOSS	db	%LOSS
354.00	51.00	404.00	63.50
355.00	51.25	405.00	63.75
356.00	51.50	406.00	64.00
357.00	51.75	407.00	64.25
358.00	52.00	408.00	64.50
359.00	52.25	409.00	64.75
360.00	52.50	410.00	65.00
361.00	52.75	411.00	65.25
362.00	53.00	412.00	65.50
363.00	53.25	413.00	65.75
364.00	53.50	414.00	66.00
365.00	53.75	415.00	66.25
366.00	54.00	416.00	66.50
367.00	54.25	417.00	66.75
368.00	54.50	418.00	67.00
369.00	54.75	419.00	67.25
370.00	55.00	420.00	67.50
371.00	55.25	421.00	67.75
372.00	55.50	422.00	68.00
373.00	55.75	423.00	68.25
374.00	56.00	424.00	68.50
375.00	56.25	425.00	68.75
376.00	56.50	426.00	69.00
377.00	56.75	427.00	69.25
378.00	57.00	428.00	69.50
379.00	57.25	429.00	69.75
380.00	57.50	430.00	70.00
381.00	57.75	431.00	70.25
382.00	58.00	432.00	70.50
383.00	58.25	433.00	70.75
384.00	58.50	434.00	71.00
385.00	58.75	435.00	71.25
386.00	59.00	436.00	71.50
387.00	59.25	437.00	71.75
388.00	59.50	438.00	72.00
389.00	59.75	439.00	72.25
390.00	60.00	440.00	72.50
391.00	60.25	441.00	72.75
392.00	60.50	442.00	73.00
393.00	60.75	443.00	73.25
394.00	61.00	444.00	73.50
395.00	61.25	445.00	73.75
396.00	61.50	446.00	74.00
397.00	61.75	447.00	74.25
398.00	62.00	448.00	74.50
399.00	62.25	449.00	74.75
400.00	62.50	450.00	75.00
401.00	62.75	451.00	75.25
402.00	63.00	452.00	75.50
403.00	63.25	453.00	75.75

db	%LOSS	db	%LOSS
454.00	76.00	504.00	88.50
455.00	76.25	505.00	88.75
456.00	76.50	506.00	89.00
457.00	76.75	507.00	89.25
458.00	77.00	508.00	89.50
459.00	77.25	509.00	89.75
460.00	77.50	510.00	90.00
461.00	77.75	511.00	90.25
462.00	78.00	512.00	90.50
463.00	78.25	513.00	90.75
464.00	78.50	514.00	91.00
465.00	78.75	515.00	91.25
466.00	79.00	516.00	91.50
467.00	79.25	517.00	91.75
468.00	79.50	518.00	92.00
469.00	79.75	519.00	92.25
470.00	80.00	520.00	92.50
471.00	80.25	521.00	92.75
472.00	80.50	522.00	93.00
473.00	80.75	523.00	93.25
474.00	81.00	524.00	93.50
475.00	81.25	525.00	93.75
476.00	81.50	526.00	94.00
477.00	81.75	527.00	94.25
478.00	82.00	528.00	94.50
479.00	82.25	529.00	94.75
480.00	82.50	530.00	95.00
481.00	82.75	531.00	95.25
482.00	83.00	532.00	95.50
483.00	83.25	533.00	95.75
484.00	83.50	534.00	96.00
485.00	83.75	535.00	96.25
486.00	84.00	536.00	96.50
487.00	84.25	537.00	96.75
488.00	84.50	538.00	97.00
489.00	84.75	539.00	97.25
490.00	85.00	540.00	97.50
491.00	85.25	541.00	97.75
492.00	85.50	542.00	98.00
493.00	85.75	543.00	98.25
494.00	86.00	544.00	98.50
495.00	86.25	545.00	98.75
496.00	86.50	546.00	99.00
497.00	86.75	547.00	99.25
498.00	87.00	548.00	99.50
499.00	87.25	549.00	99.75
500.00	87.50	550.00	100.00
501.00	87.75		
502.00	88.00		
503.00	88.25		

(d) No value is allowed for db totals of 150 or less. The value for db totals of 550 or more is 100%.

(5) Binaural hearing loss is calculated as follows:

(a) Find the percent of monaural hearing loss for each ear by using the method listed in (4) (a) - (c) above.

(b) Multiply the percent of loss in the better ear by seven.

(c) Add to that result the percent of loss in the other ear.

(d) Divide this sum by eight. This is the percent of binaural hearing loss to be compensated.

(e) This method is expressed by the formula:

$$\frac{7(A) + B}{8}$$

"A" is the percent of hearing loss in the better ear.

"B" is the percent of hearing loss in the other ear.

(6) Use the method (monaural or binaural) which results in the greater impairment.

(7) Tinnitus and other auditory losses may be determined as losses under OAR 436-035-0390.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 1/29/15 as WCD Admin. Order 15-053, eff. 3/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0255 Conversion of Hearing Loss Values to Whole Person Values

(1) The following table is used to convert a loss of hearing in one ear to a whole person (WP) value for claims with a date of injury on or after January 1, 2005:

Ear		WP	Ear		WP
1-7%	=	1%	56-60%	=	11%
8-13%	=	2%	61-65%	=	12%
14-18%	=	3%	66-71%	=	13%
19-23%	=	4%	72-76%	=	14%
24-28%	=	5%	77-81%	=	15%
29-34%	=	6%	82-86%	=	16%
35-39%	=	7%	87-92%	=	17%
40-44%	=	8%	93-97%	=	18%
45-49%	=	9%	98-100%	=	19%
50-55%	=	10%			

(2) The following table is used to convert a loss of hearing in two ears to a whole person (WP) value for claims with a date of injury on or after January 1, 2005:

Ears		WP	Ears		WP
1-2%	=	1%	51-52%	=	31%
3-4%	=	2%	53-54%	=	32%
5%	=	3%	55%	=	33%
6-7%	=	4%	56-57%	=	34%
8-9%	=	5%	58-59%	=	35%
10%	=	6%	60%	=	36%
11-12%	=	7%	61-62%	=	37%
13-14%	=	8%	63-64%	=	38%
15%	=	9%	65%	=	39%
16-17%	=	10%	66-67%	=	40%
18-19%	=	11%	68-69%	=	41%
20%	=	12%	70%	=	42%
21-22%	=	13%	71-72%	=	43%
23-24%	=	14%	73-74%	=	44%

Ears		WP	Ears		WP
25%	=	15%	75%	=	45%
26-27%	=	16%	76-77%	=	46%
28-29%	=	17%	78-79%	=	47%
30%	=	18%	80%	=	48%
31-32%	=	19%	81-82%	=	49%
33-34%	=	20%	83-84%	=	50%
35%	=	21%	85%	=	51%
36-37%	=	22%	86-87%	=	52%
38-39%	=	23%	88-89%	=	53%
40%	=	24%	90%	=	54%
41-42%	=	25%	91-92%	=	55%
43-44%	=	26%	93-94%	=	56%
45%	=	27%	95%	=	57%
46-47%	=	28%	96-97%	=	58%
48-49%	=	29%	98-99%	=	59%
50%	=	30%	100%	=	60%

Stat. Auth.: ORS 656.726;
Stats. Implemented: ORS 656.214
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0260 Visual Loss

(1) Visual loss due to a work-related illness or injury is rated for central visual acuity, integrity of the peripheral visual fields, and ocular motility. For ocular disturbances that cause visual impairment that is not reflected in visual acuity, visual fields or ocular motility refer to section (5) of this rule. Visual loss is measured with best correction, using the lenses recommended by the worker's physician. For lacrimal system disturbances refer to OAR 436-035-0440.

(2) Ratings for loss in central visual acuity are calculated for each eye as follows:

(a) Reports for central visual acuity must be for distance and near acuity.

(b) The ratings for loss of distance acuity are as follows, reported in standard increments of Snellen notation for English and Metric 6:

English	Metric 6	% Loss
20/15	6/5	0
20/20	6/6	0
20/25	6/7.5	5
20/30	6/10	10
20/40	6/12	15
20/50	6/15	25
20/60	6/20	35
20/70	6/22	40
20/80	6/24	45
20/100	6/30	50
20/125	6/38	60
20/150	6/50	70
20/200	6/60	80
20/300	6/90	85
20/400	6/120	90

English	Metric 6	% Loss
Able to count fingers at 4 feet		95
Not able to count fingers at 4 feet		100

(c) The ratings for loss of near acuity are as follows: reported in standard increments of Snellen 14/14 notation, Revised Jaeger Standard, or American Point-type notation:

Near Snellen inches	Revised Jaeger Standard	American Point-type	% Loss
14/14	1	3	0
14/18	2	4	0
14/21	3	5	5
14/24	4	6	7
14/28	5	7	10
14/35	6	8	50
14/40	7	9	55
14/45	8	10	60
14/60	9	11	80
14/70	10	12	85
14/80	11	13	87
14/88	12	14	90
14/112	13	21	95
14/140	14	23	98

(d) Once the ratings for near and distance acuity are found, add them and divide by two. The value which results is the rating for lost central visual acuity.

(e) If a lens has been removed and a prosthetic lens implanted, an additional 25%, is to be combined (not added) with the percent loss for central visual acuity to determine total central visual acuity, as shown in table (g).

(f) If a lens has been removed and there is no prosthetic lens implanted, an additional 50% is to be combined (not added) with the percent loss for central visual acuity to determine total central visual acuity, as shown in table (g).

(g) The table below may be substituted for combining central visual acuity and the loss of a lens for a total central visual acuity. The table displays the percent loss of central vision for the range of near and distance acuity combined with lens removal for a total central visual acuity. The upper figure is to be used when the lens is present (as found in (d)), the middle figure is to be used when the lens is absent and a prosthetic lens has been implanted (as found in (e)), and the lower figure is to be used when the lens is absent with no implant (as found in (f)). If near acuity is reported in Revised Jaeger Standard or American Point-type, convert these findings to Near Snellen for rating purposes under (2)(c) of this rule when using this table.

Rating for distance in feet		Near Snellen rating inches (under (c))						
		14/14	14/18	14/21	14/24	14/28	14/35	14/40
20/15	(d)	0	0	3	4	5	25	28
	(e)	25	25	27	28	29	44	46
	(f)	50	50	52	52	53	63	64
20/20	(d)	0	0	3	4	5	25	28
	(e)	25	25	27	28	29	44	46
	(f)	50	50	52	52	53	63	64
20/25	(d)	3	3	5	6	8	28	30
	(e)	27	27	29	30	31	46	48
	(f)	52	52	53	53	54	64	65
20/30	(d)	5	5	8	9	10	30	33
	(e)	29	29	31	32	33	48	50
	(f)	53	53	54	55	55	65	67
20/40	(d)	8	8	10	11	13	33	35
	(e)	31	31	33	33	35	50	51
	(f)	54	54	55	56	57	67	68
20/50	(d)	13	13	15	16	18	38	40
	(e)	35	35	36	37	39	54	55
	(f)	57	57	58	58	59	69	70
20/60	(d)	18	18	20	21	23	43	45
	(e)	39	39	40	41	42	57	59
	(f)	59	59	60	61	62	72	73
20/70	(d)	20	20	23	24	25	45	48
	(e)	40	40	42	43	44	59	61
	(f)	60	60	62	62	63	73	74
20/80	(d)	23	23	25	26	28	48	50
	(e)	42	42	44	45	46	61	63
	(f)	62	62	63	63	64	74	75
20/100	(d)	25	25	28	29	30	50	53
	(e)	44	44	46	47	48	63	65
	(f)	63	63	64	65	65	75	77
20/125	(d)	30	30	33	34	35	55	58
	(e)	48	48	50	51	51	66	68
	(f)	65	65	67	67	68	78	79
20/150	(d)	35	35	38	39	40	60	63
	(e)	51	51	54	54	55	70	72
	(f)	68	68	69	70	70	80	82
20/200	(d)	40	40	43	44	45	65	68
	(e)	55	55	57	58	59	74	76
	(f)	70	70	72	72	73	83	84
20/300	(d)	43	43	45	46	48	68	70
	(e)	57	57	59	60	61	76	78
	(f)	72	72	73	73	74	84	85
20/400	(d)	45	45	48	49	50	70	73
	(e)	59	59	61	62	63	78	80
	(f)	73	73	74	75	75	85	87
20/800	(d)	48	48	50	51	53	73	75
	(e)	61	61	63	63	65	79	81
	(f)	74	74	75	76	77	87	88

Rating for distance in feet		Near Snellen rating inches (under (c))						
		14/45	14/60	14/70	14/80	14/88	14/112	14/140
20/15	(d)	30	40	43	44	45	48	49
	(e)	48	55	57	58	59	61	62
	(f)	65	70	72	72	73	74	75
20/20	(d)	30	40	43	44	45	48	49
	(e)	48	55	57	58	59	61	62
	(f)	65	70	72	72	73	74	75
20/25	(d)	33	43	45	46	48	50	52
	(e)	50	57	59	60	61	63	64
	(f)	67	72	73	73	74	75	76
20/30	(d)	35	45	48	49	50	53	54
	(e)	51	59	61	62	63	65	66
	(f)	68	73	74	75	75	77	77
20/40	(d)	38	48	50	51	53	55	57
	(e)	54	61	63	63	65	66	68
	(f)	69	74	75	76	77	78	79
20/50	(d)	43	53	55	56	58	60	62
	(e)	57	65	66	67	68	70	72
	(f)	72	77	78	78	79	80	81
20/60	(d)	48	58	60	61	63	65	67
	(e)	61	69	70	71	72	74	75
	(f)	74	79	80	81	82	83	84
20/70	(d)	50	60	63	64	65	68	69
	(e)	63	70	72	73	74	76	77
	(f)	75	80	82	82	83	84	85
20/80	(d)	53	63	65	66	68	70	72
	(e)	65	72	74	75	76	78	79
	(f)	77	81	83	83	84	85	86
20/100	(d)	55	65	68	69	70	73	74
	(e)	66	74	76	77	78	80	81
	(f)	78	83	84	85	85	87	87
20/125	(d)	60	70	73	74	75	78	79
	(e)	70	78	80	81	81	84	84
	(f)	80	85	87	87	88	89	90
20/150	(d)	65	75	78	79	80	83	84
	(e)	74	81	84	84	85	87	88
	(f)	83	88	89	89	90	92	92
20/200	(d)	70	80	83	84	85	88	89
	(e)	78	85	87	88	89	91	92
	(f)	85	90	92	92	93	94	95
20/300	(d)	73	83	85	86	88	90	92
	(e)	80	87	89	90	91	93	94
	(f)	87	92	93	93	94	95	96
20/400	(d)	75	85	88	89	90	93	94
	(e)	81	89	91	91	93	94	96
	(f)	88	93	94	94	95	97	97
20/800	(d)	78	88	90	91	93	95	97
	(e)	84	91	93	93	94	96	98
	(f)	89	94	95	96	97	98	99

(3) Ratings for loss of visual field are based upon the results of field measurements of each eye separately using the Goldmann perimeter with a III/4e stimulus. The results may be scored in either one of the two following methods:

(a) Using the monocular Esterman Grid, count all the printed dots outside or falling on the line marking the extent of the visual field. The number of dots counted is the percentage of visual field loss; or

(b) A perimetric chart may be used which indicates the extent of retained vision for each of the eight standard 45º meridians out to 90º. The directions and normal extent of each meridian are as follows:

Minimal normal extent of peripheral visual field

Direction	Degrees
Temporally	85
Down temporally	85
Down	65
Down nasally	50
Nasally	60
Up nasally	55
Up	45
Up temporally	55
TOTAL	500

(A) Record the extent of retained peripheral visual field along each of the eight meridians. Add (do not combine) these eight figures. Find the corresponding percentage for the total retained degrees by use of the table below.

(B) For loss of a quarter or half field, first find half the sum of the normal extent of the two boundary meridians. Then add to this figure the extent of each meridian included within the retained field. This results in a figure which may be applied in the chart below.

(C) Visual field loss due to scotoma in areas other than the central visual field is rated by adding the degrees lost within the scotoma along affected meridians and subtracting that amount from the retained peripheral field. That figure is then applied to the chart below.

Total degrees retained	% of loss	Total degrees retained	% of loss	Total degrees retained	% of loss
0	100	170	66	340	32
5	99	175	65	345	31
10	98	180	64	350	30
15	97	185	63	355	29
20	96	190	62	360	28
25	95	195	61	365	27
30	94	200	60	370	26
35	93	205	59	375	25
40	92	210	58	380	24
45	91	215	57	385	23
50	90	220	56	390	22
55	89	225	55	395	21
60	88	230	54	400	20
65	87	235	53	405	19
70	86	240	52	410	18
75	85	245	51	415	17
80	84	250	50	420	16
85	83	255	49	425	15
90	82	260	48	430	14
95	81	265	47	435	13
100	80	270	46	440	12
105	79	275	45	445	11
110	78	280	44	450	10
115	77	285	43	455	9
120	76	290	42	460	8
125	75	295	41	465	7
130	74	300	40	470	6
135	73	305	39	475	5
140	72	310	38	480	4
145	71	315	37	485	3
150	70	320	36	490	2
155	69	325	35	495	1
160	68	330	34	500	0
165	67	335	33		

(4) Ratings for ocular motility impairment resulting in binocular diplopia are determined as follows:

(a) Determine the single highest value of loss for diplopia noted on each of the standard 45° meridians as listed in the following table.

(b) Add the values obtained for each meridian to obtain the total impairment for loss of ocular motility. A total of 100% or more is rated as 100% of the eye. As an example: Diplopia on looking horizontally off center from 30 degrees in a left direction is valued at 10%. Diplopia in the same eye when looking horizontally off center from 21 to 30 degrees in a right direction is valued at 20%. The impairments for diplopia in both ranges are added, so the impairment rating would be 10% plus 20% resulting in a total loss of ocular motility of 30%.

Direction of gaze	Distance from point of fixation	% of loss
central	central vision to 20 degrees	100
down	21 degrees to 30 degrees	50
down	beyond 30 degrees	30
right	21 degrees to 30 degrees	20
right	beyond 30 degrees	10
down right	21 degrees to 30 degrees	20
down right	beyond 30 degrees	10
left	21 degrees to 30 degrees	20
left	beyond 30 degrees	10
down left	21 degrees to 30 degrees	20
down left	beyond 30 degrees	10
up	beyond 20 degrees	10
up right	beyond 20 degrees	10
up left	beyond 20 degrees	10

(5) To the extent that stereopsis (depth perception), glare disturbances or monocular diplopia causes visual impairment are not reflected in visual acuity, visual field or ocular motility, the losses for visual acuity, visual fields or ocular motility will be combined with an additional 5% when in the opinion of the physician the impairment is moderate, 10% if the impairment is severe.

(6) The total rating for monocular loss is found by combining (not adding) the ratings for loss of central vision, loss of visual field, and loss of ocular motility and loss for other conditions specified in section (5) of this rule.

(7) The total rating for binocular loss is figured as follows:

(a) Find the percent of monocular loss for each eye.

(b) Multiply the percent of loss in the better eye by three.

(c) Add to that result the percent of loss in the other eye.

(d) Divide this sum by four. The result is the total percentage of binocular loss.

(e) This method is expressed by the formula

$$\frac{3(A) + B}{4}$$

"A" is the percent of loss in the better eye;

"B" is the percent of loss in the other eye.

(8) Use the method (monocular or binocular) which results in the greater impairment rating.

(9) Enucleation of an eye is rated at 100% of an eye.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0265 Conversion of Vision Loss Values to Whole Person Values

(1) The following table is used to convert vision loss in one eye to a whole person (WP) value for claims with a date of injury on or after January 1, 2005:

Eye	WP	Eye	WP	Eye	WP
1-4%	= 1%	38-40%	= 12%	73-75%	= 23%
5-8%	= 2%	41-43%	= 13%	76-79%	= 24%
9-11%	= 3%	44-46%	= 14%	80-82%	= 25%
12-14%	= 4%	47-49%	= 15%	83-85%	= 26%
15-17%	= 5%	50-53%	= 16%	86-88%	= 27%
18-20%	= 6%	54-56%	= 17%	89-91%	= 28%
21-24%	= 7%	57-59%	= 18%	92-95%	= 29%
25-27%	= 8%	60-62%	= 19%	96-98%	= 30%
28-30%	= 9%	63-66%	= 20%	99%	= 31%
31-33%	= 10%	67-69%	= 21%	100%	= 31%
34-37%	= 11%	70-72%	= 22%		

(2) The following table is used to convert vision loss in both eyes to a whole person (WP) value for claims with a date of injury on or after January 1, 2005:

Eyes	WP	Eyes	WP	Eyes	WP	Eyes	WP
1%	= 1%	26%	= 24%	51%	= 48%	76%	= 71%
2%	= 2%	27%	= 25%	52%	= 49%	77%	= 72%
3%	= 3%	28%	= 26%	53%	= 50%	78%	= 73%
4%	= 4%	29%	= 27%	54%	= 51%	79%	= 74%
5%	= 5%	30%	= 28%	55%	= 52%	80%	= 75%
6%	= 6%	31%	= 29%	56%	= 53%	81%	= 76%
7%	= 7%	32%	= 30%	57%	= 54%	82%	= 77%
8%	= 8%	33%	= 31%	58%	= 55%	83%	= 78%
9%	= 8%	34%	= 32%	59%	= 55%	84%	= 79%
10%	= 9%	35%	= 33%	60%	= 56%	85%	= 80%
11%	= 10%	36%	= 34%	61%	= 57%	86%	= 81%
12%	= 11%	37%	= 35%	62%	= 58%	87%	= 82%
13%	= 12%	38%	= 36%	63%	= 59%	88%	= 83%
14%	= 13%	39%	= 37%	64%	= 60%	89%	= 84%
15%	= 14%	40%	= 38%	65%	= 61%	90%	= 85%
16%	= 15%	41%	= 39%	66%	= 62%	91%	= 86%
17%	= 16%	42%	= 39%	67%	= 63%	92%	= 86%
18%	= 17%	43%	= 40%	68%	= 64%	93%	= 87%
19%	= 18%	44%	= 41%	69%	= 65%	94%	= 88%
20%	= 19%	45%	= 42%	70%	= 66%	95%	= 89%
21%	= 20%	46%	= 43%	71%	= 67%	96%	= 90%
22%	= 21%	47%	= 44%	72%	= 68%	97%	= 91%
23%	= 22%	48%	= 45%	73%	= 69%	98%	= 92%
24%	= 23%	49%	= 46%	74%	= 70%	99%	= 93%
25%	= 24%	50%	= 47%	75%	= 71%	100%	= 94%

Stat. Auth.: ORS 656.726:
Stats. Implemented: ORS 656.214
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0330 Shoulder Joint

(1) The following ratings are for loss of forward elevation (flexion) in the shoulder joint:

Retained Motion/Percentage of Impairment

0° = 13.0%	30°- 40° = 6.0%	100°-120° = 3.0%
1° = 12.7%	41° = 5.9%	121° = 2.9%
2° = 12.4%	42° = 5.8%	122° = 2.8%
3° = 12.1%	43° = 5.7%	123° = 2.7%
4° = 11.8%	44° = 5.6%	124° = 2.6%
5° = 11.5%	45° = 5.5%	125° = 2.5%
6° = 11.2%	46° = 5.4%	126° = 2.4%
7° = 10.9%	47° = 5.3%	127° = 2.3%
8° = 10.6%	48° = 5.2%	128° = 2.2%
9° = 10.3%	49° = 5.1%	129° = 2.1%
10° = 10.0%	50°- 60° = 5.0%	130°-140° = 2.0%
11° = 9.7%	61° = 4.9%	141° = 1.9%
12° = 9.4%	62° = 4.8%	142° = 1.8%
13° = 9.1%	63° = 4.7%	143° = 1.7%
14° = 8.8%	64° = 4.6%	144° = 1.6%
15° = 8.5%	65° = 4.5%	145° = 1.5%
16° = 8.2%	66° = 4.4%	146° = 1.4%
17° = 7.9%	67° = 4.3%	147° = 1.3%
18° = 7.6%	68° = 4.2%	148° = 1.2%
19° = 7.3%	69° = 4.1%	149° = 1.1%
20° = 7.0%	70°- 90° = 4.0%	150°-170° = 1.0%
21° = 6.9%	91° = 3.9%	171° = 0.9%
22° = 6.8%	92° = 3.8%	172° = 0.8%
23° = 6.7%	93° = 3.7%	173° = 0.7%
24° = 6.6%	94° = 3.6%	174° = 0.6%
25° = 6.5%	95° = 3.5%	175° = 0.5%
26° = 6.4%	96° = 3.4%	176° = 0.4%
27° = 6.3%	97° = 3.3%	177° = 0.3%
28° = 6.2%	98° = 3.2%	178° = 0.2%
29° = 6.1%	99° = 3.1%	179° = 0.1%
		180° = 0.0%

(2) The following ratings are for forward elevation (flexion) ankylosis in the shoulder joint:

Joint Ankylosed at/Percentage of Impairment

0° = 15.0%	50° = 10.0%	80° = 15.0%
1° = 14.7%	51° = 10.2%	81° = 15.1%
2° = 14.4%	52° = 10.4%	82° = 15.2%
3° = 14.1%	53° = 10.6%	83° = 15.3%
4° = 13.8%	54° = 10.8%	84° = 15.4%
5° = 13.5%	55° = 11.0%	85° = 15.5%
6° = 13.2%	56° = 11.2%	86° = 15.6%
7° = 12.9%	57° = 11.4%	87° = 15.7%
8° = 12.6%	58° = 11.6%	88° = 15.8%
9° = 12.3%	59° = 11.8%	89° = 15.9%
10° = 12.0%	60° = 12.0%	90°-100° = 16.0%
11° = 11.7%	61° = 12.1%	101° = 16.1%
12° = 11.4%	62° = 12.2%	102° = 16.2%
13° = 11.1%	63° = 12.3%	103° = 16.3%
14° = 10.8%	64° = 12.4%	104° = 16.4%
15° = 10.5%	65° = 12.5%	105° = 16.5%
16° = 10.2%	66° = 12.6%	106° = 16.6%
17° = 9.9%	67° = 12.7%	107° = 16.7%
18° = 9.6%	68° = 12.8%	108° = 16.8%
19° = 9.3%	69° = 12.9%	109° = 16.9%
20°- 40° = 9.0%	70° = 13.0%	110°-150° = 17.0%
41° = 9.1%	71° = 13.2%	151° = 17.1%
42° = 9.2%	72° = 13.4%	152° = 17.2%
43° = 9.3%	73° = 13.6%	153° = 17.3%
44° = 9.4%	74° = 13.8%	154° = 17.4%
45° = 9.5%	75° = 14.0%	155° = 17.5%
46° = 9.6%	76° = 14.2%	156° = 17.6%
47° = 9.7%	77° = 14.4%	157° = 17.7%
48° = 9.8%	78° = 14.6%	158° = 17.8%
49° = 9.9%	79° = 14.8%	159° = 17.9%
		160°-180° = 18.0%

(3) The following ratings are for loss of backward elevation (extension) in the shoulder joint:

Retained Motion/Percentage of Impairment

0° = 2.0%	7° = 1.3%	44° = 0.6%
1° = 1.9%	8° = 1.2%	45° = 0.5%
2° = 1.8%	9° = 1.1%	46° = 0.4%
3° = 1.7%	10°-40° = 1.0%	47° = 0.3%
4° = 1.6%	41° = 0.9%	48° = 0.2%
5° = 1.5%	42° = 0.8%	49° = 0.1%
6° = 1.4%	43° = 0.7%	50° = 0.0%

(4) The following ratings are for backward elevation (extension) ankylosis in the shoulder joint:

Joint Ankylosed at/Percentage of Impairment

0°-10° = 15.0%	20°-30° = 16.0%	40° = 17.0%
11° = 15.1%	31° = 16.1%	41° = 17.1%
12° = 15.2%	32° = 16.2%	42° = 17.2%
13° = 15.3%	33° = 16.3%	43° = 17.3%
14° = 15.4%	34° = 16.4%	44° = 17.4%
15° = 15.5%	35° = 16.5%	45° = 17.5%
16° = 15.6%	36° = 16.6%	46° = 17.6%
17° = 15.7%	37° = 16.7%	47° = 17.7%
18° = 15.8%	38° = 16.8%	48° = 17.8%
19° = 15.9%	39° = 16.9%	49° = 17.9%
		50° = 18.0%

(5) The following ratings are for loss of abduction in the shoulder joint:

Retained Motion/Percentage of Impairment

0° = 7.0%	20°- 60° = 4.0%	90°-120° = 2.0%
1° = 6.9%	61° = 3.9%	121° = 1.9%
2° = 6.8%	62° = 3.8%	122° = 1.8%
3° = 6.7%	63° = 3.7%	123° = 1.7%

4° = 6.6%	64° = 3.6%	124° = 1.6%
5° = 6.5%	65° = 3.5%	125° = 1.5%
6° = 6.4%	66° = 3.4%	126° = 1.4%
7° = 6.3%	67° = 3.3%	127° = 1.3%
8° = 6.2%	68° = 3.2%	128° = 1.2%
9° = 6.1%	69° = 3.1%	129° = 1.1%
10° = 6.0%	70°- 80° = 3.0%	130°-160° = 1.0%
11° = 5.8%	81° = 2.9%	161° = 0.9%
12° = 5.6%	82° = 2.8%	162° = 0.8%
13° = 5.4%	83° = 2.7%	163° = 0.7%
14° = 5.2%	84° = 2.6%	164° = 0.6%
15° = 5.0%	85° = 2.5%	165° = 0.5%
16° = 4.8%	86° = 2.4%	166° = 0.4%
17° = 4.6%	87° = 2.3%	167° = 0.3%
18° = 4.4%	88° = 2.2%	168° = 0.2%
19° = 4.2%	89° = 2.1%	169° = 0.1%
		170°-180° = 0.0%

(6) The following ratings are for abduction ankylosis in the shoulder joint:

Joint Ankylosed at/Percentage of Impairment

0° = 8.0%	37° = 5.7%	84° = 8.4%
1° = 7.9%	38° = 5.8%	85° = 8.5%
2° = 7.8%	39° = 5.9%	86° = 8.6%
3° = 7.7%	40°-50° = 6.0%	87° = 8.7%
4° = 7.6%	51° = 6.1%	88° = 8.8%
5° = 7.5%	52° = 6.2%	89° = 8.9%
6° = 7.4%	53° = 6.3%	90°-100° = 9.0%
7° = 7.3%	54° = 6.4%	101° = 9.1%
8° = 7.2%	55° = 6.5%	102° = 9.2%
9° = 7.1%	56° = 6.6%	103° = 9.3%
10° = 7.0%	57° = 6.7%	104° = 9.4%
11° = 6.8%	58° = 6.8%	105° = 9.5%
12° = 6.6%	59° = 6.9%	106° = 9.6%
13° = 6.4%	60°-70° = 7.0%	107° = 9.7%
14° = 6.2%	71° = 7.1%	108° = 9.8%
15° = 6.0%	72° = 7.2%	109° = 9.9%
16° = 5.8%	73° = 7.3%	110°-140° = 10.0%
17° = 5.6%	74° = 7.4%	141° = 10.1%
18° = 5.4%	75° = 7.5%	142° = 10.2%
19° = 5.2%	76° = 7.6%	143° = 10.3%
20°-30° = 5.0%	77° = 7.7%	144° = 10.4%
31° = 5.1%	78° = 7.8%	145° = 10.5%
32° = 5.2%	79° = 7.9%	146° = 10.6%
33° = 5.3%	80° = 8.0%	147° = 10.7%
34° = 5.4%	81° = 8.1%	148° = 10.8%
35° = 5.5%	82° = 8.2%	149° = 10.9%
36° = 5.6%	83° = 8.3%	150°-180° = 11.0%

(7) The following ratings are for loss of adduction in the shoulder joint:

Retained Motion/Percentage of Impairment

0°-30° = 1.0%	34° = 0.6%	38° = 0.2%
31° = 0.9%	35° = 0.5%	39° = 0.1%
32° = 0.8%	36° = 0.4%	40-50° = 0.0%
33° = 0.7%	37° = 0.3%	

(8) The following ratings are for adduction ankylosis in the shoulder joint:

Joint Ankylosed at/Percentage of Impairment

0° = 8.0%	10° = 9.0%	20°-40° = 10.0%
1° = 8.1%	11° = 9.1%	41° = 10.1%
2° = 8.2%	12° = 9.2%	42° = 10.2%
3° = 8.3%	13° = 9.3%	43° = 10.3%
4° = 8.4%	14° = 9.4%	44° = 10.4%
5° = 8.5%	15° = 9.5%	45° = 10.5%
6° = 8.6%	16° = 9.6%	46° = 10.6%
7° = 8.7%	17° = 9.7%	47° = 10.7%
8° = 8.8%	18° = 9.8%	48° = 10.8%
9° = 8.9%	19° = 9.9%	49° = 10.9%
		50° = 11.0%

(9) The following ratings are for loss of internal rotation in the shoulder joint:

Retained Motion/Percentage of Impairment

0°- 20° = 3.0%	30°- 50° = 2.0%	60°- 70° = 1.0%
21° = 2.9%	51° = 1.9%	71° = 0.9%
22° = 2.8%	52° = 1.8%	72° = 0.8%
23° = 2.7%	53° = 1.7%	73° = 0.7%
24° = 2.6%	54° = 1.6%	74° = 0.6%
25° = 2.5%	55° = 1.5%	75° = 0.5%
26° = 2.4%	56° = 1.4%	76° = 0.4%
27° = 2.3%	57° = 1.3%	77° = 0.3%
28° = 2.2%	58° = 1.2%	78° = 0.2%
29° = 2.1%	59° = 1.1%	79° = 0.1%
		80°- 90° = 0.0%

(10) The following ratings are for internal rotation ankylosis in the shoulder joint:

Joint Ankylosed at/Percentage of Impairment

0°-60° = 4.0%	70° = 5.0%	80° = 6.0%
61° = 4.1%	71° = 5.1%	81° = 6.1%
62° = 4.2%	72° = 5.2%	82° = 6.2%
63° = 4.3%	73° = 5.3%	83° = 6.3%
64° = 4.4%	74° = 5.4%	84° = 6.4%
65° = 4.5%	75° = 5.5%	85° = 6.5%
66° = 4.6%	76° = 5.6%	86° = 6.6%
67° = 4.7%	77° = 5.7%	87° = 6.7%
68° = 4.8%	78° = 5.8%	88° = 6.8%
69° = 4.9%	79° = 5.9%	89° = 6.9%
		90° = 7.0%

(11) The following ratings are for loss of external rotation in the shoulder joint:

Retained Motion/Percentage of Impairment

0° - 50° = 1.0%	54° = 0.6%	58° = 0.2%
51° = 0.9%	55° = 0.5%	59° = 0.1%
52° = 0.8%	56° = 0.4%	60°- 90° = 0.0%
53° = 0.7%	57° = 0.3%	

(12) The following ratings are for external rotation ankylosis in the shoulder joint:

Joint Ankylosed at/Percentage of Impairment

0° = 4.0%	10°- 30° = 5.0%	40°- 60° = 6.0%
1° = 4.1%	31° = 5.1%	61° = 6.1%
2° = 4.2%	32° = 5.2%	62° = 6.2%
3° = 4.3%	33° = 5.3%	63° = 6.3%
4° = 4.4%	34° = 5.4%	64° = 6.4%
5° = 4.5%	35° = 5.5%	65° = 6.5%
6° = 4.6%	36° = 5.6%	66° = 6.6%
7° = 4.7%	37° = 5.7%	67° = 6.7%
8° = 4.8%	38° = 5.8%	68° = 6.8%
9° = 4.9%	39° = 5.9%	69° = 6.9%
		70°- 90° = 7.0%

(13) Shoulder surgery is rated as follows:

Shoulder Surgery	Impairment
Partial resection of either clavicle (no additional value is allowed for multiple partial resections of the clavicle)	5%
Total removal of either clavicle	15%
Partial resection of the acromion (no additional value is allowed for multiple partial resections of the acromion)	5%
Total shoulder arthroplasty	30%
Repeat total shoulder replacement	10%

(14) Chronic dislocations of the shoulder joint or diastasis of a sternal joint, are valued at 15% impairment when a preponderance of medical opinion places permanent new restrictions on the worker which necessitate a reduction in the strength lifting category under OAR 436-035-0012.

(15) When two or more ranges of motion are restricted, add the impairment values for decreased range of motion.

(16) When two or more ankylosis positions are documented, select the one direction representing the largest impairment. That will be the impairment value for the shoulder represented by ankylosis.

(17) Valid losses of strength in the shoulder or back, substantiated by clinical findings, are valued based on the peripheral nerve supplying (innervating) the muscle(s) demonstrating the decreased strength, as described in the following table and as modified under OAR 436-035-0011(7):

Unilateral Nerve	% Impairment Due to Loss of Strength
Accessory (Spinal Accessory)	10%
Anterior Thoracic (Pectoral)	3%
Axillary	21%
Dorsal Scapular	3%
Long Thoracic	9%
Subscapular	3%
Suprascapular	9%
Thoracodorsal	6%

Example 1: A worker suffers a dislocation of the shoulder. Upon recovery, the attending physician reports 4/5 strength of the deltoid muscle. The axillary nerve innervates the deltoid muscle. Complete loss of the axillary nerve is a 21% impairment value. 4/5 strength, under OAR 436-035-0011(7), is a 20% loss of strength. Final impairment is determined by multiplying 21% by 20% for a final value of 4.2% impairment of the shoulder.

Example 2: A worker suffers a laceration of the long thoracic nerve. Upon recovery, the attending physician reports 0/5 strength of the upper back. The long thoracic nerve has a 9% impairment value. 0/5 strength, under OAR 436-035-0011(7), is 100% loss of strength. Final impairment is determined by multiplying 9% by 100% for a final value of 9% impairment of the upper back.

(18) Multiple or bilateral decreased strength impairment findings are determined by combining the values in section (17) of this rule.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 12/5/05 as WCD Admin. Order 05-074, eff. 1/1/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0340 Hip

(1) When a preponderance of objective medical evidence supports findings that reduced ranges of motion of the hip do not involve the pelvis or acetabulum, the impairment determination is valued under OAR 436-035-0220. If the reduced ranges of motion are a residual of pelvic or acetabular involvement, the impairment is determined under this rule.

(2) The following ratings are for loss of forward flexion in the hip joint:

Retained motion/percentage of impairment

0° = 9.0%	30°-40° = 6.0%	70° = 3.0%
1° = 8.9%	41° = 5.9%	71° = 2.9%
2° = 8.8%	42° = 5.8%	72° = 2.8%
3° = 8.7%	43° = 5.7%	73° = 2.7%
4° = 8.6%	44° = 5.6%	74° = 2.6%
5° = 8.5%	45° = 5.5%	75° = 2.5%
6° = 8.4%	46° = 5.4%	76° = 2.4%
7° = 8.3%	47° = 5.3%	77° = 2.3%
8° = 8.2%	48° = 5.2%	78° = 2.2%
9° = 8.1%	49° = 5.1%	79° = 2.1%
10° = 8.0%	50° = 5.0%	80° = 2.0%
11° = 7.9%	51° = 4.9%	81° = 1.9%
12° = 7.8%	52° = 4.8%	82° = 1.8%
13° = 7.7%	53° = 4.7%	83° = 1.7%
14° = 7.6%	54° = 4.6%	84° = 1.6%
15° = 7.5%	55° = 4.5%	85° = 1.5%
16° = 7.4%	56° = 4.4%	86° = 1.4%
17° = 7.3%	57° = 4.3%	87° = 1.3%
18° = 7.2%	58° = 4.2%	88° = 1.2%
19° = 7.1%	59° = 4.1%	89° = 1.1%
20° = 7.0%	60° = 4.0%	90° = 1.0%
21° = 6.9%	61° = 3.9%	91° = 0.9%
22° = 6.8%	62° = 3.8%	92° = 0.8%
23° = 6.7%	63° = 3.7%	93° = 0.7%
24° = 6.6%	64° = 3.6%	94° = 0.6%
25° = 6.5%	65° = 3.5%	95° = 0.5%
26° = 6.4%	66° = 3.4%	96° = 0.4%
27° = 6.3%	67° = 3.3%	97° = 0.3%
28° = 6.2%	68° = 3.2%	98° = 0.2%
29° = 6.1%	69° = 3.1%	99° = 0.1%
		100° = 0.0%

(3) The following ratings are for forward flexion ankylosis in the hip joint:

Joint ankylosed at/percentage of impairment

0° = 33.0%	34° = 27.2%	68° = 37.4%
1° = 32.7%	35° = 27.5%	69° = 37.7%
2° = 32.4%	36° = 27.8%	70° = 38.0%
3° = 32.1%	37° = 28.1%	71° = 38.3%
4° = 31.8%	38° = 28.4%	72° = 38.6%
5° = 31.5%	39° = 28.7%	73° = 38.9%
6° = 31.2%	40° = 29.0%	74° = 39.2%
7° = 30.9%	41° = 29.3%	75° = 39.5%
8° = 30.6%	42° = 29.6%	76° = 39.8%
9° = 30.3%	43° = 29.9%	77° = 40.1%
10° = 30.0%	44° = 30.2%	78° = 40.4%
11° = 29.6%	45° = 30.5%	79° = 40.7%
12° = 29.2%	46° = 30.8%	80° = 41.0%
13° = 28.8%	47° = 31.1%	81° = 41.3%
14° = 28.4%	48° = 31.4%	82° = 41.6%
15° = 28.0%	49° = 31.7%	83° = 41.9%
16° = 27.6%	50° = 32.0%	84° = 42.2%
17° = 27.2%	51° = 32.3%	85° = 42.5%
18° = 26.8%	52° = 32.6%	86° = 42.8%
19° = 26.4%	53° = 32.9%	87° = 43.1%
20° = 26.0%	54° = 33.2%	88° = 43.4%
21° = 25.6%	55° = 33.5%	89° = 43.7%
22° = 25.2%	56° = 33.8%	90° = 44.0%
23° = 24.8%	57° = 34.1%	91° = 44.3%
24° = 24.4%	58° = 34.4%	92° = 44.6%
25° = 24.0%	59° = 34.7%	93° = 44.9%
26° = 24.4%	60° = 35.0%	94° = 45.2%
27° = 24.8%	61° = 35.3%	95° = 45.5%
28° = 25.2%	62° = 35.6%	96° = 45.8%
29° = 25.6%	63° = 35.9%	97° = 46.1%
30° = 26.0%	64° = 36.2%	98° = 46.4%
31° = 26.3%	65° = 36.5%	99° = 46.7%
32° = 26.6%	66° = 36.8%	100° = 47.0%
33° = 26.9%	67° = 37.1%	

(4) The following ratings are for loss of backward extension in the hip joint:

Retained motion/percentage of impairment

0° = 3.0%	10° = 2.0%	20° = 1.0%
1° = 2.9%	11° = 1.9%	21° = 0.9%
2° = 2.8%	12° = 1.8%	22° = 0.8%
3° = 2.7%	13° = 1.7%	23° = 0.7%
4° = 2.6%	14° = 1.6%	24° = 0.6%
5° = 2.5%	15° = 1.5%	25° = 0.5%
6° = 2.4%	16° = 1.4%	26° = 0.4%
7° = 2.3%	17° = 1.3%	27° = 0.3%
8° = 2.2%	18° = 1.2%	28° = 0.2%
9° = 2.1%	19° = 1.1%	29° = 0.1%
		30° = 0.0%

(5) The following ratings are for backward extension ankylosis of the hip joint:

Joint ankylosed at/percentage of impairment

0° = 33.0%	10° = 38.0%	20° = 43.0%
1° = 33.5%	11° = 38.5%	21° = 43.4%
2° = 34.0%	12° = 39.0%	22° = 43.8%
3° = 34.5%	13° = 39.5%	23° = 44.2%
4° = 35.0%	14° = 40.0%	24° = 44.6%
5° = 35.5%	15° = 40.5%	25° = 45.0%
6° = 36.0%	16° = 41.0%	26° = 45.4%
7° = 36.5%	17° = 41.5%	27° = 45.8%
8° = 37.0%	18° = 42.0%	28° = 46.2%
9° = 37.5%	19° = 42.5%	29° = 46.6%
		30° = 47.0%

(6) The following ratings are for loss of abduction in the hip joint:

Retained motion/percentage of impairment

0° = 8.0%	14° = 5.2%	28° = 2.4%
1° = 7.8%	15° = 5.0%	29° = 2.2%
2° = 7.6%	16° = 4.8%	30° = 2.0%
3° = 7.4%	17° = 4.6%	31° = 1.8%
4° = 7.2%	18° = 4.4%	32° = 1.6%
5° = 7.0%	19° = 4.2%	33° = 1.4%
6° = 6.8%	20° = 4.0%	34° = 1.2%
7° = 6.6%	21° = 3.8%	35° = 1.0%
8° = 6.4%	22° = 3.6%	36° = 0.8%
9° = 6.2%	23° = 3.4%	37° = 0.6%
10° = 6.0%	24° = 3.2%	38° = 0.4%
11° = 5.8%	25° = 3.0%	39° = 0.2%
12° = 5.6%	26° = 2.8%	40° = 0.0%
13° = 5.4%	27° = 2.6%	

(7) The following ratings are for abduction ankylosis in the hip joint:

Joint ankylosed at/percentage of impairment

0° = 33.0%	14° = 38.2%	28° = 43.2%
1° = 33.4%	15° = 38.5%	29° = 43.6%
2° = 33.8%	16° = 38.8%	30° = 44.0%
3° = 34.2%	17° = 39.1%	31° = 44.3%
4° = 34.6%	18° = 39.4%	32° = 44.6%
5° = 35.0%	19° = 39.7%	33° = 44.9%
6° = 35.4%	20° = 40.0%	34° = 45.2%
7° = 35.8%	21° = 40.4%	35° = 45.5%
8° = 36.2%	22° = 40.8%	36° = 45.8%
9° = 36.6%	23° = 41.2%	37° = 46.1%
10° = 37.0%	24° = 41.6%	38° = 46.4%
11° = 37.3%	25° = 42.0%	39° = 46.7%
12° = 37.6%	26° = 42.4%	40° = 47.0%
13° = 37.9%	27° = 42.8%	

(8) The following ratings are for loss of adduction in the hip joint:

Retained motion/percentage of impairment

0° = 4.0%	7° = 2.6%	14° = 1.2%
1° = 3.8%	8° = 2.4%	15° = 1.0%
2° = 3.6%	9° = 2.2%	16° = 0.8%
3° = 3.4%	10° = 2.0%	17° = 0.6%
4° = 3.2%	11° = 1.8%	18° = 0.4%
5° = 3.0%	12° = 1.6%	19° = 0.2%
6° = 2.8%	13° = 1.4%	20° = 0.0%

(9) The following ratings are for adduction ankylosis in the hip joint:

Joint ankylosed at/percentage of impairment

0° = 33.0%	7° = 37.9%	14° = 42.8%
1° = 33.7%	8° = 38.6%	15° = 43.5%
2° = 34.4%	9° = 39.3%	16° = 44.2%
3° = 35.1%	10° = 40.0%	17° = 44.9%
4° = 35.8%	11° = 40.7%	18° = 45.6%
5° = 36.5%	12° = 41.4%	19° = 46.3%
6° = 37.2%	13° = 42.1%	20° = 47.0%

(10) The following ratings are for loss of internal rotation of the hip joint:

Retained motion/percentage of impairment

0° = 5.0%	14° = 3.6%	28° = 2.2%
1° = 4.9%	15° = 3.5%	29° = 2.1%
2° = 4.8%	16° = 3.4%	30° = 2.0%
3° = 4.7%	17° = 3.3%	31° = 1.8%
4° = 4.6%	18° = 3.2%	32° = 1.6%
5° = 4.5%	19° = 3.1%	33° = 1.4%
6° = 4.4%	20° = 3.0%	34° = 1.2%
7° = 4.3%	21° = 2.9%	35° = 1.0%
8° = 4.2%	22° = 2.8%	36° = 0.8%
9° = 4.1%	23° = 2.7%	37° = 0.6%
10° = 4.0%	24° = 2.6%	38° = 0.4%
11° = 3.9%	25° = 2.5%	39° = 0.2%
12° = 3.8%	26° = 2.4%	40° = 0.0%
13° = 3.7%	27° = 2.3%	

(11) The following ratings are for internal rotation ankylosis of the hip joint:

Joint ankylosed at/percentage of impairment

0° = 33.0%	14° = 38.2%	28° = 43.2%
1° = 33.4%	15° = 38.5%	29° = 43.6%
2° = 33.8%	16° = 38.8%	30° = 44.0%
3° = 34.2%	17° = 39.1%	31° = 44.3%
4° = 34.6%	18° = 39.4%	32° = 44.6%
5° = 35.0%	19° = 39.7%	33° = 44.9%
6° = 35.4%	20° = 40.0%	34° = 45.2%
7° = 35.8%	21° = 40.4%	35° = 45.5%
8° = 36.2%	22° = 40.8%	36° = 45.8%
9° = 36.6%	23° = 41.2%	37° = 46.1%
10° = 37.0%	24° = 41.6%	38° = 46.4%
11° = 37.3%	25° = 42.0%	39° = 46.7%
12° = 37.6%	26° = 42.4%	40° = 47.0%
13° = 37.9%	27° = 42.8%	

(12) The following ratings are for loss of external rotation of the hip joint:

Retained motion/percentage of impairment

0° = 7.0%	17° = 4.3%	34° = 2.6%
1° = 6.8%	18° = 4.2%	35° = 2.5%
2° = 6.6%	19° = 4.1%	36° = 2.4%
3° = 6.4%	20° = 4.0%	37° = 2.3%
4° = 6.2%	21° = 3.9%	38° = 2.2%
5° = 6.0%	22° = 3.8%	39° = 2.1%
6° = 5.8%	23° = 3.7%	40° = 2.0%
7° = 5.6%	24° = 3.6%	41° = 1.8%
8° = 5.4%	25° = 3.5%	42° = 1.6%
9° = 5.2%	26° = 3.4%	43° = 1.4%
10° = 5.0%	27° = 3.3%	44° = 1.2%
11° = 4.9%	28° = 3.2%	45° = 1.0%
12° = 4.8%	29° = 3.1%	46° = 0.8%
13° = 4.7%	30° = 3.0%	47° = 0.6%
14° = 4.6%	31° = 2.9%	48° = 0.4%
15° = 4.5%	32° = 2.8%	49° = 0.2%
16° = 4.4%	33° = 2.7%	50° = 0.0%

(13) The following ratings are for external rotation ankylosis of the hip joint:

Joint ankylosed at/percentage of impairment

0° = 33.0%	17° = 38.1%	34° = 42.2%
1° = 33.3%	18° = 38.4%	35° = 42.5%
2° = 33.6%	19° = 38.7%	36° = 42.8%
3° = 33.9%	20° = 39.0%	37° = 43.1%
4° = 34.2%	21° = 39.2%	38° = 43.4%
5° = 34.5%	22° = 39.4%	39° = 43.7%
6° = 34.8%	23° = 39.6%	40° = 44.0%
7° = 35.1%	24° = 39.8%	41° = 44.3%
8° = 35.4%	25° = 40.0%	42° = 44.6%
9° = 35.7%	26° = 40.2%	43° = 44.9%
10° = 36.0%	27° = 40.4%	44° = 45.2%
11° = 36.3%	28° = 40.6%	45° = 45.5%
12° = 36.6%	29° = 40.8%	46° = 45.8%
13° = 36.9%	30° = 41.0%	47° = 46.1%
14° = 37.2%	31° = 41.3%	48° = 46.4%
15° = 37.5%	32° = 41.6%	49° = 46.7%
16° = 37.8%	33° = 41.9%	50° = 47.0%

(14) When two or more ankylosis positions are documented, select the one direction representing the largest impairment. That will be the impairment value for the hip represented by ankylosis.

(15) A value of 13% is determined for a total hip replacement (both femoral and acetabular resurfacing or components involved). If a total hip replacement surgery occurs following an earlier femoral head replacement surgery under OAR 436-035-0230(5), both impairment values are rated.

(16) A value of 5% is awarded for a repeat total hip replacement surgery.

(17) Total value for loss of range of motion is obtained by adding (not combining) the values for each range of motion.

(18) The final value for the hip is obtained by combining (not adding) the values in sections (15), (16) and (17) of this rule.

(19) Healed displaced fractures in the hip may cause leg length discrepancies. Impairment is determined under OAR 436-035-0230.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0350 General Spinal Findings

(1) The following ratings are for fractured vertebrae:

(a) For a compression fracture of a single vertebral body:

% of compression	% impairment		
	Cervical	Thoracic	Lumbosacral
1% - 25%	4	2	5
26% - 50%	6	3	7
>50%	10	5	12

(b) A compression fracture followed by a corpectomy receives both the surgical value and the maximum compression fracture value.

(c) A fracture of one or more of the posterior elements of a vertebra (spinous process, pedicles, laminae, articular process, odontoid process, or transverse process) is valued per vertebra as follows:

% impairment		
Cervical	Thoracic	Lumbosacral
4	2	5

(2) For the purposes of this section, the cervical, thoracic, and lumbosacral regions are considered separate body parts. Values determined within one body part are first added, then the total impairment value is obtained by combining the different body part values. The following values are for surgical procedures performed on the spine.

	% impairment		
	Cervical	**Thoracic**	**Lumbosacral**
1st surgical procedure Involving 1 disc, 1 or 2 vertebrae, or any combination	8%	4%	9%
Additional disc(s) or vertebra treated within the same region/body part	Add 1% for each additional disc or vertebra.		
Subsequent surgical procedures	Add 1% for each disc or vertebrae treated.		

(3) For injuries that result in loss of strength in the back, refer to OAR 436-035-0330(17) and (18).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0360 Spinal Ranges of Motion

(1) For the purpose of determining impairment due to loss of spinal range of motion, sections (2) through (12) of this rule shall apply when the physician uses an inclinometer to measure impairment.

(2) The following ratings are for loss of flexion in the cervical region:

Retained Motion/Percentage of Impairment

0° = 6.0%	20° = 4.0%	40° = 2.0%
1° = 5.9%	21° = 3.9%	41° = 1.9%
2° = 5.8%	22° = 3.8%	42° = 1.8%
3° = 5.7%	23° = 3.7%	43° = 1.7%
4° = 5.6%	24° = 3.6%	44° = 1.6%
5° = 5.5%	25° = 3.5%	45° = 1.5%
6° = 5.4%	26° = 3.4%	46° = 1.4%
7° = 5.3%	27° = 3.3%	47° = 1.3%
8° = 5.2%	28° = 3.2%	48° = 1.2%
9° = 5.1%	29° = 3.1%	49° = 1.1%
10° = 5.0%	30° = 3.0%	50° = 1.0%
11° = 4.9%	31° = 2.9%	51° = 0.9%
12° = 4.8%	32° = 2.8%	52° = 0.8%
13° = 4.7%	33° = 2.7%	53° = 0.7%
14° = 4.6%	34° = 2.6%	54° = 0.6%
15° = 4.5%	35° = 2.5%	55° = 0.5%
16° = 4.4%	36° = 2.4%	56° = 0.4%
17° = 4.3%	37° = 2.3%	57° = 0.3%
18° = 4.2%	38° = 2.2%	58° = 0.2%
19° = 4.1%	39° = 2.1%	59° = 0.1%
		60° = 0.0%

(3) The following ratings are for loss of extension in the cervical region:

Retained Motion/Percentage of Impairment

0° = 6.00%	25° = 4.00%	50° = 2.00%
1° = 5.92%	26° = 3.92%	51° = 1.92%
2° = 5.84%	27° = 3.84%	52° = 1.84%
3° = 5.76%	28° = 3.76%	53° = 1.76%
4° = 5.68%	29° = 3.68%	54° = 1.68%
5° = 5.60%	30° = 3.60%	55° = 1.60%
6° = 5.52%	31° = 3.52%	56° = 1.52%
7° = 5.44%	32° = 3.44%	57° = 1.44%
8° = 5.36%	33° = 3.36%	58° = 1.36%
9° = 5.28%	34° = 3.28%	59° = 1.28%
10° = 5.20%	35° = 3.20%	60° = 1.20%
11° = 5.12%	36° = 3.12%	61° = 1.12%
12° = 5.04%	37° = 3.04%	62° = 1.04%
13° = 4.96%	38° = 2.96%	63° = 0.96%
14° = 4.88%	39° = 2.88%	64° = 0.88%
15° = 4.80%	40° = 2.80%	65° = 0.80%
16° = 4.72%	41° = 2.72%	66° = 0.72%
17° = 4.64%	42° = 2.64%	67° = 0.64%
18° = 4.56%	43° = 2.56%	68° = 0.56%
19° = 4.48%	44° = 2.48%	69° = 0.48%
20° = 4.40%	45° = 2.40%	70° = 0.40%
21° = 4.32%	46° = 2.32%	71° = 0.32%
22° = 4.24%	47° = 2.24%	72° = 0.24%
23° = 4.16%	48° = 2.16%	73° = 0.16%
24° = 4.08%	49° = 2.08%	74° = 0.08%
		75° = 0.00%

(4) The following ratings are for loss of right or left lateral flexion in the cervical region:

Retained Motion/Percentage of Impairment

0° = 4.00%	15° = 2.00%	30° = 1.00%
1° = 3.87%	16° = 1.93%	31° = 0.93%
2° = 3.73%	17° = 1.87%	32° = 0.87%
3° = 3.60%	18° = 1.80%	33° = 0.80%
4° = 3.47%	19° = 1.73%	34° = 0.73%
5° = 3.33%	20° = 1.67%	35° = 0.67%
6° = 3.20%	21° = 1.60%	36° = 0.60%
7° = 3.07%	22° = 1.53%	37° = 0.53%
8° = 2.93%	23° = 1.47%	38° = 0.47%
9° = 2.80%	24° = 1.40%	39° = 0.40%
10° = 2.67%	25° = 1.33%	40° = 0.33%
11° = 2.53%	26° = 1.27%	41° = 0.27%
12° = 2.40%	27° = 1.20%	42° = 0.20%
13° = 2.27%	28° = 1.13%	43° = 0.13%
14° = 2.13%	29° = 1.07%	44° = 0.07%
		45° = 0.00%

(5) The following ratings are for loss of right or left rotation in the cervical region:

Retained Motion/Percentage of Impairment

0° = 6.0%	27° = 3.3%	54° = 1.30%
1° = 5.9%	28° = 3.2%	55° = 1.25%
2° = 5.8%	29° = 3.1%	56° = 1.20%
3° = 5.7%	30° = 3.0%	57° = 1.15%
4° = 5.6%	31° = 2.9%	58° = 1.10%
5° = 5.5%	32° = 2.8%	59° = 1.05%
6° = 5.4%	33° = 2.7%	60° = 1.00%
7° = 5.3%	34° = 2.6%	61° = 0.95%
8° = 5.2%	35° = 2.5%	62° = 0.90%
9° = 5.1%	36° = 2.4%	63° = 0.85%
10° = 5.0%	37° = 2.3%	64° = 0.80%
11° = 4.9%	38° = 2.2%	65° = 0.75%
12° = 4.8%	39° = 2.1%	66° = 0.70%
13° = 4.7%	40° = 2.0%	67° = 0.65%
14° = 4.6%	41° = 1.95%	68° = 0.60%
15° = 4.5%	42° = 1.90%	69° = 0.55%
16° = 4.4%	43° = 1.85%	70° = 0.50%
17° = 4.3%	44° = 1.80%	71° = 0.45%
18° = 4.2%	45° = 1.75%	72° = 0.40%
19° = 4.1%	46° = 1.70%	73° = 0.35%
20° = 4.0%	47° = 1.65%	74° = 0.30%
21° = 3.9%	48° = 1.60%	75° = 0.25%
22° = 3.8%	49° = 1.55%	76° = 0.20%
23° = 3.7%	50° = 1.50%	77° = 0.15%
24° = 3.6%	51° = 1.45%	78° = 0.10%
25° = 3.5%	52° = 1.40%	79° = 0.05%
26° = 3.4%	53° = 1.35%	80° = 0.00%

(6) The following ratings are for loss of flexion in the thoracic region:

Retained Motion/Percentage of Impairment

0° = 4.00%	17° = 1.87%	34° = 0.80%
1° = 3.87%	18° = 1.80%	35° = 0.75%
2° = 3.73%	19° = 1.73%	36° = 0.70%
3° = 3.60%	20° = 1.67%	37° = 0.65%
4° = 3.47%	21° = 1.60%	38° = 0.60%
5° = 3.33%	22° = 1.53%	39° = 0.55%
6° = 3.20%	23° = 1.47%	40° = 0.50%
7° = 3.07%	24° = 1.40%	41° = 0.45%
8° = 2.93%	25° = 1.33%	42° = 0.40%
9° = 2.80%	26° = 1.27%	43° = 0.35%
10° = 2.67%	27° = 1.20%	44° = 0.30%
11° = 2.53%	28° = 1.13%	45° = 0.25%
12° = 2.40%	29° = 1.07%	46° = 0.20%
13° = 2.27%	30° = 1.00%	47° = 0.15%
14° = 2.13%	31° = 0.95%	48° = 0.10%
15° = 2.00%	32° = 0.90%	49° = 0.05%
16° = 1.93%	33° = 0.85%	50° = 0.00%

(7) The following ratings are for loss of right or left rotation in the thoracic region:

Retained Motion/Percentage of Impairment

0° = 3.0%	10° = 2.0%	20° = 1.0%
1° = 2.9%	11° = 1.9%	21° = 0.9%
2° = 2.8%	12° = 1.8%	22° = 0.8%
3° = 2.7%	13° = 1.7%	23° = 0.7%
4° = 2.6%	14° = 1.6%	24° = 0.6%
5° = 2.5%	15° = 1.5%	25° = 0.5%
6° = 2.4%	16° = 1.4%	26° = 0.4%
7° = 2.3%	17° = 1.3%	27° = 0.3%
8° = 2.2%	18° = 1.2%	28° = 0.2%
9° = 2.1%	19° = 1.1%	29° = 0.1%
		30° = 0.0%

(8) The following ratings are for loss of flexion in the lumbosacral region:

True Lumbar Flexion Angle	
Retained Motion	**Spine**
0° - 14°	10%
15° - 29°	7%
30° - 44°	4%
45° - 59°	2%
60° +	0%

(9) The following ratings are for loss of extension in the lumbosacral region:

Retained Motion/Percentage of Impairment

0° = 7.0%	9° = 5.2%	18° = 2.4%
1° = 6.8%	10° = 5.0%	19° = 2.2%
2° = 6.6%	11° = 4.6%	20° = 2.0%
3° = 6.4%	12° = 4.2%	21° = 1.6%
4° = 6.2%	13° = 3.8%	22° = 1.2%
5° = 6.0%	14° = 3.4%	23° = 0.8%
6° = 5.8%	15° = 3.0%	24° = 0.4%
7° = 5.6%	16° = 2.8%	25° = 0.0%
8° = 5.4%	17° = 2.6%	

(10) The following ratings are for loss of right or left lateral flexion of the lumbosacral region:

Retained Motion/Percentage of Impairment

0° = 5.0%	9° = 3.2%	18° = 1.4%
1° = 4.8%	10° = 3.0%	19° = 1.2%
2° = 4.6%	11° = 2.8%	20° = 1.0%
3° = 4.4%	12° = 2.6%	21° = 0.8%
4° = 4.2%	13° = 2.4%	22° = 0.6%
5° = 4.0%	14° = 2.2%	23° = 0.4%
6° = 3.8%	15° = 2.0%	24° = 0.2%
7° = 3.6%	16° = 1.8%	25° = 0.0%
8° = 3.4%	17° = 1.6%	

(11) For a total impairment value due to loss of motion, as measured by inclinometer, in any of the cervical, thoracic or lumbosacral regions, add (do not combine) values for loss of motion for each region.

(12) In order to rate range of motion loss and surgery in one region, combine (do not add) the total range of motion loss in

that region with the appropriate total surgical impairment value of the corresponding region. Combine the value from each region to find the total impairment of the spine.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 12/5/05 as WCD Admin. Order 05-074, eff. 1/1/06

436-035-0370 Pelvis

(1) The following ratings are for a fractured pelvis which heals with displacement and deformity:

in the symphysis pubis	15%
in the sacroiliac joint, with diastasis	10%
in the sacrum	10%
in the ischium	10%
in the coccyx, with nonunion or excision	5%
in each inferior or superior ramus	2%
in the ilium	2%
in the acetabulum	Rate only loss of hip motion as in OAR 436-035-0340

(2) A hemipelvectomy receives 25% for the pelvis, and the accompanying loss of the leg is determined under OAR 436-035-0140(1).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0375 Abdomen

Use the following classifications when impairment has resulted from a permanent and palpable defect in the supporting structures of the abdominal wall:

(1) **Class 1**: 5% for a slight protrusion at the site of the defect with increased abdominal pressure that is readily reducible; or occasional mild discomfort at the site of the defect, which limits the worker in one or more activities of daily living (ADL).

(2) **Class 2**: 15% for frequent or persistent protrusion at the site of the defect with increased pressure that is manually reducible; or frequent discomfort, which limits the worker from heavy lifting, but does not hamper some ADL.

(3) **Class 3**: 25% for persistent, irreducible, or irreparable protrusion at the site of the defect and there is a limitation in the worker's ADL.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 5/5/10 as WCD Admin. Order 10-051, eff. 6/1/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0380 Cardiovascular System

(1) Impairments of the cardiovascular system are determined based on objective findings that result in the following conditions: valvular heart disease, coronary heart disease, hypertensive cardiovascular disease, cardiomyopathies, pericardial disease, or cardiac arrhythmias. Each of these conditions will be described and quantified. In most circumstances, the physician should observe the patient during exercise testing.

(2) Valvular Heart Disease: Impairment resulting from work related valvular heart disease is rated according to the following classes:

Class 1 (5% Impairment)

The worker has evidence by physical examination or laboratory studies of valvular heart disease, but no symptoms in the performance of ordinary daily activities or even upon moderately heavy exertion; and

The worker does not require continuous treatment, although prophylactic antibiotics may be recommended at the time of a surgical procedure to reduce the risk of bacterial endocarditis; and

The worker remains free of signs of congestive heart failure; and

There are no signs of ventricular hypertrophy or dilation, and the severity of the stenosis or regurgitation is estimated to be mild; or

In the worker who has recovered from valvular heart surgery, all of the above criteria are met.

Class 2 (20% Impairment)

The worker has evidence by physical examination or laboratory studies of valvular heart disease, and there are no symptoms in the performance of ordinary daily activities, but symptoms develop on moderately heavy physical exertion; or

The worker requires moderate dietary adjustment or drugs to prevent symptoms or to remain free of the signs of congestive heart failure or other consequences of valvular heart disease, such as syncope, chest pain and emboli; or

The worker has signs or laboratory evidence of cardiac chamber hypertrophy or dilation, and the severity of the stenosis or regurgitation is estimated to be moderate, and surgical correction is not feasible or advisable; or

The worker has recovered from valvular heart surgery and meets the above criteria.

Class 3 (40% Impairment)

The worker has signs of valvular heart disease and has slight to moderate symptomatic discomfort during the performance of ordinary daily activities; and

Dietary therapy or drugs do not completely control symptoms or prevent congestive heart failure; and

The worker has signs or laboratory evidence of cardiac chamber hypertrophy or dilation, the severity of the stenosis or regurgitation is estimated to be moderate or severe, and surgical correction is not feasible; or

The worker has recovered from heart valve surgery but continues to have symptoms and signs of congestive heart failure including cardiomegaly.

Class 4 (78% Impairment)

The worker has signs by physical examination of valvular heart disease, and symptoms at rest or in the performance of less than ordinary daily activities; and

Dietary therapy and drugs cannot control symptoms or prevent signs of congestive heart failure; and

The worker has signs or laboratory evidence of cardiac chamber hypertrophy or dilation; and the severity of the stenosis or regurgitation is estimated to be moderate or severe, and surgical correction is not feasible; or

The worker has recovered from valvular heart surgery but continues to have symptoms or signs of congestive heart failure.

(3) Coronary Heart Disease: Impairment resulting from work related coronary heart disease is rated according to the following classes:

Class 1 (5% Impairment)

This class of impairment should be reserved for the worker with an equivocal history of angina pectoris on whom coronary angiography is performed, or for a worker on whom coronary angiography is performed for other reasons and in whom is found less than 50% reduction in the cross sectional area of a coronary artery.

Class 2 (20% Impairment)

The worker has history of a myocardial infarction or angina pectoris that is documented by appropriate laboratory studies, but at the time of evaluation the worker has no symptoms while performing ordinary daily activities or even moderately heavy physical exertion; and

The worker may require moderate dietary adjustment or medication to prevent angina or to remain free of signs and symptoms of congestive heart failure; and

The worker is able to walk on the treadmill or bicycle ergometer and obtain a heart rate of 90% of his or her predicted maximum heart rate without developing significant ST segment shift, ventricular tachycardia, or hypotension; or

The worker has recovered from coronary artery surgery or angioplasty, remains asymptomatic during ordinary daily activities, and is able to exercise as outlined above. If the worker is taking a beta adrenergic blocking agent, he or she should be able to walk on the treadmill to a level estimated to cause an energy expenditure of at least 10 METS* as a substitute for the heart rate target.

*METS is a term that represents the multiples of resting metabolic energy used for any given activity. One MET is 3.5ml/(kg x min).

Class 3 (40% Impairment)

The worker has a history of myocardial infarction that is documented by appropriate laboratory studies, or angina pectoris that is documented by changes on a resting or exercise ECG or radioisotope study that are suggestive of ischemia; or

The worker has either a fixed or dynamic focal obstruction of at least 50% of a coronary artery, demonstrated by angiography; and

The worker requires moderate dietary adjustment or drugs to prevent frequent angina or to remain free of symptoms and signs of congestive heart failure, but may develop angina pectoris or symptoms of congestive heart failure after moderately heavy physical exertion; or

The worker has recovered from coronary artery surgery or angioplasty, continues to require treatment, and has the symptoms described above.

Class 4 (78% Impairment)

The worker has history of a myocardial infarction that is documented by appropriate laboratory studies or angina pectoris that has been documented by changes of a resting ECG or radioisotope study that are highly suggestive of myocardial ischemia; or

The worker has either fixed or dynamic focal obstruction of at least 50% of one or more coronary arteries, demonstrated by angiography; and

Moderate dietary adjustments or drugs are required to prevent angina or to remain free of symptoms and signs of congestive heart failure, but the worker continues to develop symptoms of angina pectoris or congestive heart failure during ordinary daily activities; or

There are signs or laboratory evidence of cardiac enlargement and abnormal ventricular function; or

The worker has recovered from coronary artery bypass surgery or angioplasty and continues to require treatment and have symptoms as described above.

(4) Hypertensive Cardiovascular Disease: Impairment resulting from work related hypertensive cardiovascular disease is rated according to the following classes:

Class 1 (5% Impairment)

The worker has no symptoms and the diastolic pressures are repeatedly in excess of 90 mm Hg; and

The worker is taking antihypertensive medications but has none of the following abnormalities: (1) abnormal urinalysis or renal function tests; (2) history of hypertensive cerebrovascular disease; (3) evidence of left ventricular hypertrophy; (4) hypertensive vascular abnormalities of the optic fundus, except minimal narrowing of arterioles.

Class 2 (20% Impairment)

The worker has no symptoms and the diastolic pressures are repeatedly in excess of 90 mm Hg; and

The worker is taking antihypertensive medication and has any of the following abnormalities: (1) proteinuria and abnormalities of the urinary sediment, but no impairment of renal function as measured by blood urea nitrogen (BUN) and serum creatinine determinations; (2) history of hypertensive cerebrovascular damage; (3) definite hypertensive changes in the retinal arterioles, including crossing defects or old exudates.

Class 3 (40% Impairment)

The worker has no symptoms and the diastolic pressure readings are consistently in excess of 90 mm Hg; and

The worker is taking antihypertensive medication and has any of the following abnormalities: (1) diastolic pressure readings usually in excess of 120 mm Hg; (2) proteinuria or abnormalities in the urinary sediment, with evidence of

impaired renal function as measured by elevated BUN and serum creatinine, or by creatinine clearance below 50%; (3) hypertensive cerebrovascular damage with permanent neurological residual; (4) left ventricular hypertrophy based on findings of physical examination, ECG, or chest radiograph, but no symptoms, signs or evidence by chest radiograph of congestive heart failure; or (5) retinopathy, with definite hypertensive changes in the arterioles, such as "copper" or "silver wiring," or A-V crossing changes, with or without hemorrhages and exudates.

Class 4 (78% Impairment)

The worker has a diastolic pressure consistently in excess of 90 mm Hg; and

The worker is taking antihypertensive medication and has any two of the following abnormalities; (1) diastolic pressure readings usually in excess of 120 mm Hg; (2) proteinuria and abnormalities in the urinary sediment, with impaired renal function and evidence of nitrogen retention as measured by elevated BUN and serum creatinine or by creatinine clearance below 50%; (3) hypertensive cerebrovascular damage with permanent neurological deficits; (4) left ventricular hypertrophy; (5) retinopathy as manifested by hypertensive changes in the arterioles, retina, or optic nerve; (6) history of congestive heart failure; or

The worker has left ventricular hypertrophy with the persistence of congestive heart failure despite digitalis and diuretics.

(5) Cardiomyopathy: Impairment resulting from work related cardiomyopathies is rated according to the following classes:

Class 1 (5% Impairment)

The worker is asymptomatic and there is evidence of impaired left ventricular function from physical examination or laboratory studies; and

There is no evidence of congestive heart failure or cardiomegaly from physical examination or laboratory studies.

Class 2 (20% Impairment)

The worker is asymptomatic and there is evidence of impaired left ventricular function from physical examination or laboratory studies; and

Moderate dietary adjustment or drug therapy is necessary for the worker to be free of symptoms and signs of congestive heart failure; or

The worker has recovered from surgery for the treatment of hypertrophic cardiomyopathy and meets the above criteria.

Class 3 (40% Impairment)

The worker develops symptoms of congestive heart failure on greater than ordinary daily activities and there is evidence of abnormal ventricular function from physical examination or laboratory studies; and

Moderate dietary restriction or the use of drugs is necessary to minimize the worker's symptoms, or to prevent the appearance of signs of congestive heart failure or evidence of it by laboratory study; OR

The worker has recovered from surgery for the treatment of hypertrophic cardiomyopathy and meets the criteria described above.

Class 4 (78% Impairment)

The worker is symptomatic during ordinary daily activities despite the appropriate use of dietary adjustment and drugs, and there is evidence of abnormal ventricular function from physical examination or laboratory studies; or

There are persistent signs of congestive heart failure despite the use of dietary adjustment and drugs; or

The worker has recovered from surgery for the treatment of hypertrophic cardiomyopathy and meets the above criteria.

(6) Pericardial Disease: Impairment resulting from work related pericardial disease is rated according to the following classes:

Class 1 (5% Impairment)

The worker has no symptoms in the performance of ordinary daily activities or moderately heavy physical exertion, but does have evidence from either physical examination or laboratory studies of pericardial heart disease; and

Continuous treatment is not required, and there are no signs of cardiac enlargement, or of congestion of lungs or other organs; or

In the worker who has had surgical removal of the pericardium, there are no adverse consequences of the surgical removal and the worker meets the criteria above.

Class 2 (20% Impairment)

The worker has no symptoms in the performance of ordinary daily activities, but does have evidence from either physical examination or laboratory studies of pericardial heart disease; but

Moderate dietary adjustment or drugs are required to keep the worker free from symptoms and signs of congestive heart failure; or

The worker has signs or laboratory evidence of cardiac chamber hypertrophy or dilation; or

The worker has recovered from surgery to remove the pericardium and meets the criteria above.

Class 3 (40% Impairment)

The worker has symptoms on performance of greater than ordinary daily activities despite dietary or drug therapy, and the worker has evidence from physical examination or laboratory studies, of pericardial heart disease; and

Physical signs are present, or there is laboratory evidence of cardiac chamber enlargement or there is evidence of significant pericardial thickening and calcification; or

The worker has recovered from surgery to remove the pericardium but continues to have the symptoms, signs and laboratory evidence described above.

Class 4 (78% Impairment)

The worker has symptoms on performance of ordinary daily activities in spite of using appropriate dietary restrictions or

drugs, and the worker has evidence from physical examination or laboratory studies, of pericardial heart disease; and

The worker has signs or laboratory evidence of congestion of the lungs or other organs; or

The worker has recovered from surgery to remove the pericardium and continues to have symptoms, signs, and laboratory evidence described above.

(7) Arrythmias: Impairment resulting from work related cardiac arrhythmias* is rated according to the following classes:

Class 1 (5% Impairment)

The worker is asymptomatic during ordinary activities and a cardiac arrhythmia is documented by ECG; and

There is no documentation of three or more consecutive ectopic beats or periods of asystole greater than 1.5 seconds, and both the atrial and ventricular rates are maintained between 50 and 100 beats per minute; and

There is no evidence of organic heart disease.

* If an arrhythmia is a result of organic heart disease, the arrhythmia should be rated separately and combined with the impairment rating for the organic heart disease.

Class 2 (20% Impairment)

The worker is asymptomatic during ordinary daily activities and a cardiac arrhythmia* is documented by ECG; and

Moderate dietary adjustment, or the use of drugs, or an artificial pacemaker, is required to prevent symptoms related to the cardiac arrhythmia; or

The arrhythmia persists and there is organic heart disease.

Class 3 (40% Impairment)

The worker has symptoms despite the use of dietary therapy or drugs or of an artificial pacemaker and a cardiac arrhythmia* is documented with ECG; but

The worker is able to lead an active life and the symptoms due to the arrhythmia are limited to infrequent palpitations and episodes of light-headedness, or other symptoms of temporarily inadequate cardiac output.

Class 4 (78% Impairment)

The worker has symptoms due to documented cardiac arrhythmia* that are constant and interfere with ordinary daily activities; or

The worker has frequent symptoms of inadequate cardiac output documented by ECG to be due to frequent episodes of cardiac arrhythmia; or

The worker continues to have episodes of syncope that are either due to, or have a high probability of being related to, the arrhythmia. To fit into this category of impairment, the symptoms must be present despite the use of dietary therapy, drugs, or artificial pacemakers.

(8) For heart transplants an impairment value of 50% is given. This value is combined with any other findings of impairment of the heart.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0385 Respiratory System

(1) For the purpose of this rule, the following definitions apply:

(a) FVC is forced vital capacity.

(b) FEV1 is forced expiratory volume in the first second.

(c) Dco refers to diffusing capacity of carbon monoxide.

(d) VO2 Max is measured exercise capacity.

(2) Lung impairment is rated according to the following classes:

(a) **Class 1:** 0% for FVC greater than or equal to 80% of predicted, and FEV1 greater than or equal to 80% of predicted, and FEV1/FVC greater than or equal to 70%, and Dco greater than or equal to 80% of predicted; or VO2 Max greater than 25 ml/(kg x min).

(b) **Class 2:** 18% for FVC between 60% and 79% of predicted, or FEV1 between 60% and 79% of predicted, or FEV1/FVC between 60% and 69%, or Dco between 60% and 79% of predicted, or VO2 Max greater than or equal to 20 ml/(kg x min) and less than or equal to 25 ml/(kg x min).

(c) **Class 3:** 38% for FVC between 51% and 59% of predicted, or FEV1 between 41% and 59% of predicted, or FEV1/FVC between 41% and 59%, or Dco between 41% and 59% of predicted, or VO2 Max greater than or equal to 15 ml/(kg x min) and less than 20 ml/(kg x min).

(d) **Class 4:** 75% for FVC less than or equal to 50% of predicted, or FEV1 less than or equal to 40% of predicted, or FEV1/FVC less than or equal to 40%, or Dco less than or equal to 40% of predicted, or VO2 Max less than 15 ml/(kg x min).

(3) Lung cancer - All persons with lung cancers as a result of a compensable industrial injury or occupational disease are to be considered Class 4 impaired at the time of diagnosis. At a re-evaluation, one year after the diagnosis is established, if the person is found to be free of all evidence of tumor, then he or she should be rated under the physiologic parameters in OAR 436-035-0385(2). If there is evidence of tumor, the person is determined to have Class 4 impairment.

(4) Asthma - Reversible obstructive airway disease is rated under the classes of respiratory impairment described in section (2) of this rule. The impairment is based on the best of three successive tests performed at least one week apart at a time when the patient is receiving optimal medical therapy. In addition, a worker may also have impairment determined under OAR 436-035-0450.

(5) Allergic respiratory responses - For workers who have developed an allergic respiratory response to physical, chemical, or biological agents refer to OAR 436-035-0450. Methacholine inhalation testing is permitted at the discretion of the physician. Where methacholine inhalation testing leaves the worker at risk, level of impairment may be based on review of the medical record.

(6) Impairment from air passage defects is determined according to the following classes:

Class 1 (5% Impairment)

Dyspnea does not occur at rest.

Dyspnea is not produced by walking or climbing stairs freely, performance of other usual activities of daily living, stress, prolonged exertion, hurrying, hill climbing, or recreation requiring intensive effort or similar activity.

Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to 4th ring), lower trachea, bronchi, or complete obstruction of the nose (bilateral), or nasopharynx.

Class 2 (20% Impairment)

Dyspnea does not occur at rest.

Dyspnea is not produced by walking freely on the level, climbing at least one flight of ordinary stairs, or the performance of other usual activities of daily living.

Dyspnea is produced by stress, prolonged exertion, hurrying, hill-climbing, recreation except sedentary forms, or similar activity.

Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to 4th ring), lower trachea, bronchi; or complete obstruction of the nose (bilateral), or nasopharynx.

Class 3 (40% Impairment)

Dyspnea does not occur at rest.

Dyspnea is produced by walking more than one or two blocks on the level or climbing one flight of ordinary stairs even with periods of rest; performance of other usual activities of daily living, stress, hurrying, hill-climbing, recreation or similar activity.

Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to 4th ring), lower trachea, or bronchi.

Class 4 (78% Impairment)

Dyspnea occurs at rest, although worker is not necessarily bedridden.

Dyspnea is aggravated by the performance of any of the usual activities of daily living beyond personal cleansing, dressing, grooming or its equivalent.

Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to 4th ring), lower trachea, or bronchi.

(7) Residual impairment from a lobectomy is valued based on the physiological parameters found under section (2) of this rule.

(8) For injuries that result in impaired ability to speak, the following classes are used to rate the worker's ability to speak in relation to: audibility (ability to speak loudly enough to be heard); intelligibility (ability to articulate well enough to be understood); and functional efficiency (ability to produce a serviceably fast rate of speech and to sustain it over a useful period of time).

(a) **Class 1:** 4% when speech can be produced with sufficient intensity and articular quality to meet most of the needs of everyday speech communication; some hesitation or slowness of speech may exist; certain phonetic units may be difficult or impossible to produce; listeners may require the speaker to repeat.

(b) **Class 2:** 9% when speech can be produced with sufficient intensity and articular quality to meet many of the needs of everyday speech communication; speech may be discontinuous, hesitant or slow; can be understood by a stranger but may have many inaccuracies; may have difficulty being heard in loud places.

(c) **Class 3:** 18% when speech can be produced with sufficient intensity and articular quality to meet some of the needs of everyday speech communication; often consecutive speech can only be sustained for brief periods; can converse with family and friends but may not be understood by strangers; may often be asked to repeat; has difficulty being heard in loud places; voice tires rapidly and tends to become inaudible after a few seconds.

(d) **Class 4:** 26% when speech can be produced with sufficient intensity and articular quality to meet few of the needs of everyday speech communication; consecutive speech limited to single words or short phrases; speech is labored and impractically slow; can produce some phonetic units but may use approximations that are unintelligible or out of context; may be able to whisper audibly but has no voice.

(e) **Class 5:** 33% for complete inability to meet the needs of everyday speech communication.

(9) Workers with successful permanent tracheostomy or stoma should be rated at 25% impairment of the respiratory system.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 10-26-04 as WCD Admin. Order 04-063, eff 1-1-05
Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0390 Cranial Nerves/Brain

(1) Impairment of the first cranial nerve (olfactory) resulting in either complete inability to detect odors or alteration of the sense of smell is 3% impairment.

(2) Ratings given for impairment of the second cranial nerve (optic) are rated based on their effects on vision under OAR 436-035-0260.

(3) Ratings given for impairment in the third cranial nerve (oculomotor), fourth cranial nerve (trochlear), and sixth cranial nerve (abducens) are rated based on their effects on ocular motility under OAR 436-035-0260.

(4) Ratings given for impairment of the fifth cranial nerve (trigeminal) are as follows:

(a) For loss or alteration of sensation in the trigeminal distribution on one side: 10%; on both sides: 35%.

(b) The rating given for loss of motor function for each trigeminal Nerve is 5%.

(c) The rating given for loss of motor function of both trigeminal Nerves is determined under OAR 436-035-0385 and 436-035-0420.

(5) Ratings given for impairment of the sixth cranial nerve (abducens) are described in section (3) of this rule.

(6) Ratings given for impairment of the seventh cranial nerve (facial) are as follows:

(a) No rating is given for loss of sensation from impairment of one or both facial nerves.

(b) If impairment of one or both facial nerves results in loss or alteration of the sense of taste, the rating is 3%.

(c) Motor loss on one side of the face due to impairment of the facial nerve is rated at 15% for a complete loss, or 5% for a partial loss.

(d) Motor loss on both sides of the face due to impairment of the facial nerve is rated at 45% for a complete loss, or 20% for a partial loss.

(7) Ratings given for impairment of the eighth cranial nerve (auditory) are determined according to their effects on hearing under OAR 436-035-0250. Other ratings for loss of function most commonly associated with this nerve include the following:

(a) For permanent disturbances resulting in disequilibrium which limits activities the impairment is rated under the following:

(A) **Class 1**: 8% when signs of disequilibrium are present with supporting objective findings and the usual activities of daily living (ADL) are performed without assistance.

(B) **Class 2**: 23% when signs of disequilibrium are present with supporting objective findings and the usual activities of daily living can be performed without assistance, and the worker is unable to operate a motor vehicle.

(C) **Class 3**: 48% when signs of disequilibrium are present with supporting objective findings and the usual ADL cannot be performed without assistance.

(D) **Class 4**: 80% when signs of disequilibrium are present with supporting objective findings and the usual ADL cannot be performed without assistance, and confinement to the home or other facility is necessary.

(b) Tinnitus which by a preponderance of medical opinion requires job modification is valued at 5%. No additional impairment value is allowed for "bilateral" tinnitus.

(8) Ratings given for impairment of the ninth cranial nerve (glossopharyngeal), tenth cranial nerve (vagus), and eleventh cranial nerve (cranial accessory) are as follows:

(a) Impairment of swallowing due to damage to the ninth, tenth, or eleventh cranial nerve is determined under OAR 436-035-0420.

(b) Speech impairment due to damage to the ninth, tenth, or eleventh cranial nerve is rated under the classifications in OAR 436-035-0385(8).

(9) Ratings given for impairment of the twelfth cranial nerve (hypoglossal) are as follows:

(a) No rating is allowed for loss on one side.

(b) Bilateral loss is rated as in section (8) of this rule.

(10) Impairment for injuries to the brain or head is determined based upon a preponderance of medical opinion which applies or describes the following criteria.

(a) The existence and severity of the claimed residuals and impairments must be objectively determined by observation or examination or a preponderance of evidence, and must be within the range reasonably considered to be possible, given the nature of the original injury, based upon a preponderance of medical opinion.

(b) Emotional disturbances which are reactive to other residuals, but which are not directly related to the brain or head injury, such as frustration or depressed mood about memory deficits or work limitations, are not included under these criteria and must be addressed separately.

(c) The distinctions between classes are intended to reflect, at their most fundamental level, the impact of the residuals on two domains: impairment of ADL, and impairment of employment capacity.

(d) Where the residuals from the accepted condition and any direct medical sequelae place the worker between one or more classes, the worker is entitled to be placed in the highest class that describes the worker's impairment. There is no averaging of impairment values when a worker falls between classes.

(e) As used in these rules, episodic neurologic disorder refers to and includes any of the following:

(A) Any type of seizure disorder;

(B) Vestibular disorder, including disturbances of balance or sensorimotor integration;

(C) Neuro-ophthalmologic or oculomotor visual disorder, such as diplopia;

(D) Headaches.

CLASS 1
(10% Impairment)

Cognition: The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 9 or 10; (e.g., the worker is alert and oriented; behavior is appropriate and the worker is able to recall and integrate past and recent events). The worker is independent in ADL. If there are cognitive or memory deficits, they are no more than minimal or "nuisance" level, and do not materially impair ADL, or the type of work the worker may perform.

Language: If there is a language deficit, it is no more than minimal (e.g., language comprehension or production might be less than normal, but it is adequate for daily living).

Emotions/behavior: If there are emotional disturbances or personality changes, they are minimal and occur only transiently during stressful situations and events.

Sleep/alertness: If there are episodic sleep disturbances, fatigue, or lethargy, they are minimal (e.g., any sleeping irregularity, fatigue, or lethargy does not interfere with daily living).

Episodic neurologic disorder: If there is an episodic neurologic disorder, it is completely controlled and does not interfere with daily living.

The fundamental intent of this class is as follows: (1) ADL: The worker has "nuisance" level residual effects of head injury, which may slightly impact the manner in which ADL are performed, or the subjective ease of performance, but the worker remains fully independent in all ADL; (2) Work capacity: The "nuisance" level residuals may impact the manner in which the worker performs work tasks, or the subjective ease of performance, but the worker is not materially limited in the types of work which can be performed, as compared with pre-injury abilities.

CLASS 2
(30% Impairment)

Cognition: The worker functions at the equivalent Rancho Los Amigos Scale-Revised level of 8 (e.g., the worker is alert and oriented; behavior is appropriate and the worker is able to recall and integrate past and recent events). The worker can perform all ADL independently, but due to mild cognitive or memory deficits, may need to use compensatory strategies or devices such as multiple written reminders, alarms, or digital devices; or may sometimes require more time than normal to complete ADL; or may use occasional reminders, prompts, or minor assistance by others as a compensatory strategy, but is not dependent on others. For example, a spouse may be asked to double-check financial transactions for errors, but the worker can manage all transactions independently if necessary, and is not fundamentally dependent on the spouse for this activity. The cognitive or memory deficits limit the worker's ability to perform some types of jobs, for example, mild attention deficits may preclude work in a busy, multi-taking environment, but the worker is still employable.

Language: Language deficit is mild (e.g., language comprehension or production might occasionally interfere with daily living or limit the worker's ability to perform some types of jobs, but the worker is still employable).

Emotion/behavior: Emotional or behavioral disturbances or personality changes are mild. While they may be disproportionate to the stress or situation, they do not significantly impair the worker's ability to relate to others, or to live with others. They may limit the worker's ability to perform some types of jobs, for example, irritability may preclude jobs with high public contact; but the worker is still employable.

Sleep/alertness: Episodic sleep disturbances, fatigue, or lethargy are mild (e.g., any sleeping irregularity, fatigue, or lethargy only occasionally interferes with daily living). Sleep disturbance, or mild or episodic fatigue or lethargy, may limit the worker's ability to perform some types of jobs, for example, shift work or commercial driving; but the worker is still employable.

Episodic neurologic disorder: Any episodic neurologic disorder is not completely controlled, and results in limits in ADL performance or types of work that may be performed, but the worker is still independent in ADL and is employable. For example, headaches may intermittently interfere with daily living; diplopia which worsens with fatigue may cause the worker to have driving restrictions; vestibular symptoms may limit the worker's ability to operate industrial machinery or cause the worker to avoid heights.

The fundamental intent of this class is as follows: (1) ADL: The worker is independent in all ADL, but may require significant adaptations or modifications in normal patterns or means of ADL in order to achieve ADL-independence; (2) Work capacity: The residuals result in some type of limitation on the worker's employment capacity, restricting the range of employment options that were previously available to the worker, but the worker remains employable in most jobs for which s/he was qualified prior to injury.

CLASS 3
(50% Impairment)

Cognition: The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 7 (e.g., the worker is alert and oriented, behavior is appropriate but the worker has mild to moderate impaired judgment or mild to moderate, functionally significant cognitive or memory deficits). The judgment, cognitive, or memory deficits result in impairment sufficient that the worker regularly requires assistance or supervision in order to perform some ADL. The deficits restrict the worker to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity.

Language: Language deficit is mild to moderate (e.g., language comprehension or production deficits frequently interfere with ADL or restrict the worker to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity).

Emotions/behavior: Emotional or behavioral disturbances or personality changes are moderate, disproportionate to the stress or situation, are present at all times and significantly impair the worker's ability to relate to others or to live with others. The disturbances restrict the worker to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity.

Sleep/alertness: Episodic sleep disturbances, fatigue, or lethargy are moderate. They frequently interfere with daily living, or restrict the worker to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity.

Episodic neurologic disorder: If there is an episodic neurologic disorder, it is not completely controlled. It markedly interferes with daily living. The worker cannot operate industrial machinery, and is restricted to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity.

The fundamental intent of this class is as follows: (1) ADL: The worker is not completely independent in all ADL, and requires some type of supervision, assistance, or guidance from another person at some times for some aspects of ADL;

(2) Work capacity: The residuals result in major limitations on the worker's employment capacity with major restrictions or limitations on the worker's range of employment options.

CLASS 4
(75% Impairment)

Cognition: The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 6 (e.g., the worker has impaired judgment or significant memory deficit, such that the worker needs assistance and supervision to perform most ADL and can work only in a sheltered setting).

Language: Language deficit is moderate (e.g., language comprehension is often impaired or language production is often inappropriate or unintelligible).

Emotions/behavior: Emotional or behavioral disturbances or personality changes are moderate to severe, disproportionate to the stress or situation, are present at all times, require the worker to be supervised, or seriously limit the worker's ability to live with others. The worker can work, if at all, only in a sheltered setting.

Sleep/alertness: Episodic sleep disturbances, fatigue, or lethargy are moderate-severe (e.g., they require supervision for daily living). The worker can work, if at all, only in a sheltered setting.

Episodic neurologic disorder: If there is episodic neurologic disorder, it is of such severity and constancy that activities have to be limited and supervised. The worker needs to live in a supervised setting such as a foster home, care facility, or supervised semi-independent residence.

The fundamental intent of this class is as follows: (1) ADL: The worker is basically dependent on others for most aspects of ADL, although the worker may not need direct supervision at all times. (2) Work capacity: The worker is incapable of competitive employment and can work, if at all, only in a sheltered setting.

CLASS 5
(85% Impairment)

The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 4-5 (e.g., the worker's behavior is inappropriate, the worker is confused, not reliably oriented to time and place; the worker may be agitated and has a severe memory deficit) and the worker requires assistance and supervision to perform all ADL. Total supervision is required. The worker is incapable of any employment.

CLASS 6
(95% Impairment)

The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 1-3. The worker is comatose or the worker's responses to stimuli are localized, inconsistent or delayed.

(11) For the purpose of section (10) of this rule, the Rancho Los Amigos-Revised levels are based upon the "Eight States Levels of Cognitive Recovery" developed at the Rancho Los Amigos Hospital and co-authored by Chris Hagen, PhD, Danese Malkumus, M.A., and Patricia Durham, M.S., in 1972. These levels were revised by Danese Malkumus, M.A., and Kathryn Standenip, O.T.R., in 1974, revised by Chris Hagen, PhD, in 1999 to include ten levels, referred to as Rancho-R.

(12) For brain or head injuries that have resulted in the loss of use or function of any upper or lower extremities, a value may be allowed for the affected body part(s). Refer to the appropriate section of these standards for that determination.

(13) Headaches that are not a direct result of a brain or head injury (e.g., cervicogenic, sensory input issues, etc.) are given a value of 10% when they interfere with the activities of daily living, affect the worker's ability to regularly perform work, and require continued prescription medication or therapy. If a value for headaches is granted under section (10) of this rule, the value in this section is not granted because it is included in the impairment value for the episodic neurological disorder.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0395 Spinal Cord

(1) The spinal cord is concerned with sensory, motor, and visceral functions. Permanent impairment can result from various disorders affecting these functions. Spinal cord impairment is determined under the following classes:

(a) **Class 1**: 15% when the worker has spinal cord damage but is able to carry out the activities of daily living independently.

(b) **Class 2**: 35% when the worker is a paraplegic and requires assistive measures or devices for any of the activities of daily living.

(c) **Class 3**: 50% when the worker is a quadriplegic and requires assistive measures or devices for any of the activities of daily living.

(d) **Class 4**: 75% when the worker is a paraplegic or quadriplegic and requires the assistance of another person for any of the activities of daily living.

(e) **Class 5**: 95% when the worker is a paraplegic or quadriplegic and is dependent in all of the activities of daily living.

(f) When a value is granted under section (1) of this rule, no additional impairment value is allowed for reduced range of motion in the spine because it is included in the impairment values shown in this section.

(2) For spinal cord damage that has resulted in the loss of use or function of body part(s) other than upper and lower extremities, a value is given for other affected body part(s) or organ system(s). Refer to the appropriate section of these standards for that determination and combine with impairment valued under this rule.

(3) For spinal cord damage that has resulted in the loss of use or function of any upper or lower extremities, a value is given for the affected body part(s). Refer to the appropriate section of these standards for that determination.

(4) Episodic neurological disorders are determined under OAR 436-035-0390(10).

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0400 Mental Illness

(1) Accepted mental disorders resulting in impairment must be diagnosed by a psychiatrist or other mental health professional as provided for in a managed care organization certified under OAR chapter 436, Division 015.

(2) Diagnoses of mental disorders for the purposes of these rules follow the guidelines of the *Diagnostic and Statistical Manual of Mental Disorders DSM-IV (1994)*, published by the American Psychiatric Association. A copy of the standards referenced in this rule is available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301, 503-947-7810.

(3)The physician describes permanent changes in mental function in terms of their affect on the worker's activities of daily living (ADLs), as defined in OAR 436-035-0005(1). Additionally, the physician describes the affect on social functioning and deterioration or decompensation in work or work-like settings.

(a) Social functioning refers to an individual's capacity to interact appropriately, communicate effectively, and get along with other individuals.

(b) Deterioration or decompensation in work or work-like settings refers to repeated failure to adapt to stressful circumstances, which causes the individual either to withdraw from that situation or to experience exacerbations with accompanying difficulty in maintaining ADL, social relationships, concentration, persistence, pace, or adaptive behaviors.

(4) Loss of function attributable to permanent worsening of personality disorders may be stated as impairment only if it interferes with the worker's long-term ability to adapt to the ordinary activities and stresses of daily living. Personality disorders are rated as two classes with gradations within each class based on severity:

(a) **Class 1**: minimal (0%), mild (6%), or moderate (11%) when the worker shows little self-understanding or awareness of the mental illness; some problems with judgment; some problems with controlling personal behavior; some ability to avoid serious problems with social and personal relationships; and some ability to avoid self-harm.

(b) **Class 2**: minimal (20%), mild (29%), or moderate (38%) when the worker shows considerable loss of self control; an inability to learn from experience; and causes harm to the community or to the self.

(5) Loss of function attributable to permanent symptoms of affective disorders, anxiety disorders, somatoform disorders, and chronic adjustment disorders is rated under the following classes, with gradations within each class based on the severity of the symptoms/loss of function:

(a) **Class 1**: 0% when one or more of the following residual symptoms are noted:

Anxiety symptoms: Require little or no treatment, are in response to a particular stress situation, produce unpleasant tension while the stress lasts, and might limit some activities.

Depressive symptoms: The ADL can be carried out, but the worker might lack ambition, energy, and enthusiasm. There may be such depression-related, mentally-caused physical problems as mild loss of appetite and a general feeling of being unwell.

Phobic symptoms: Phobias the worker already suffers from may come into play, or new phobias may appear in a mild form.

Psychophysiological symptoms: Are temporary and in reaction to specific stress. Digestive problems are typical. Any treatment is for a short time and is not connected with any ongoing treatment. Any physical pathology is temporary and reversible. Conversion symptoms or hysterical symptoms are brief and do not occur very often. They might include some slight and limited physical problems (such as weakness or hoarseness) that quickly respond to treatment.

(b) **Class 2**: minimal (6%), mild (23%), or moderate (35%) when one or more of the following residual symptoms/loss of functions are noted:

Anxiety symptoms: May require extended treatment. Specific symptoms may include (but are not limited to) startle reactions, indecision because of fear, fear of being alone, and insomnia. There is no loss of intellect or disturbance in thinking, concentration, or memory.

Depressive symptoms: Last for several weeks. There are disturbances in eating and sleeping patterns, loss of interest in usual activities, and moderate retardation of physical activity. There may be thoughts of suicide. Self-care activities and personal hygiene remain good.

Phobic symptoms: Interfere with normal activities to a mild to moderate degree. Typical reactions include (but are not limited to) a desire to remain at home, a refusal to use elevators, a refusal to go into closed rooms, and an obvious reaction of fear when confronted with a situation that involves a superstition.

Psychophysiological symptoms: Require substantial treatment. Frequent and recurring problems with the organs get in the way of common activities. The problems may include (but are not limited to) diarrhea; chest pains; muscle spasms in the arms, legs, or along the backbone; a feeling of being smothered; and hyperventilation. There is no actual pathology in the organs or tissues. Conversion or hysterical symptoms result in periods of loss of physical function that occur more than twice a year, last for several weeks, and need treatment. Symptoms may include (but are not limited to) temporary hoarseness, temporary blindness, temporary weakness in the arms or the legs. These problems continue to return.

(c) **Class 3**: Minimal (50%), mild (66%), or moderate (81%) when one or more of the following residual symptoms/loss of functions are noted:

Anxiety symptoms: Fear, tension, and apprehension interfere with work or the ADL. Memory and concentration decrease or

become unreliable. Long-lasting periods of anxiety keep returning and interfere with personal relationships. The worker needs constant reassurance and comfort from family, friends, and coworkers.

Depressive symptoms: Include an obvious loss of interest in the usual ADL, including eating and self-care. These problems are long-lasting and result in loss of weight and an unkempt appearance. There may be retardation of physical activity, a preoccupation with suicide, and actual attempts at suicide. The worker may be extremely agitated on a frequent or constant basis.

Phobic symptoms: Existing phobias are intensified. In addition, new phobias develop. This results in bizarre and disruptive behavior. In the most serious cases, the worker may become home-bound, or even room-bound. Persons in this state often carry out strange rituals which require them to be isolated or protected.

Psychophysiological symptoms: Include tissue changes in one or more body systems or organs. These may not be reversible. Typical reactions include (but are not limited to) changes in the wall of the intestine that results in constant digestive and elimination problems. Conversion or hysterical symptoms include loss of physical function that occurs often and lasts for weeks or longer. Evidence of physical change follows such events. A symptomatic period (18 months or more) is associated with advanced negative changes in the tissues and organs. These include (but are not limited to) atrophy of muscles in the legs and arms. A common symptom is general flabbiness.

(6) Psychotic disorders are rated based on perception, thinking process, social behavior, and emotional control. Variations in these aspects of mental function are rated under the following classifications with gradations within each class based on severity:

(a) **Class 1**: minimal (0%), mild (6%), or moderate (11%) when one or more of the following is established:

Perception: The worker misinterprets conversations or events. It is common for persons with this problem to think others are talking about them or laughing at them.

Thinking process: The worker is absent-minded, forgetful, daydreams too much, thinks slowly, has unusual thoughts that recur, or suffers from an obsession. The worker is aware of these problems and may also show mild problems with judgment. It is also possible that the worker may have little self-understanding or understanding of the problem.

Social behavior: Small problems appear in general behavior, but do not get in the way of social or living activities. Others are not disturbed by them. The worker may be over-reactive or depressed or may neglect self-care and personal hygiene.

Emotional control: The worker may be depressed and have little interest in work or life. The worker may have an extreme feeling of well-being without reason. Controlled and productive activities are possible, but the worker is likely to be irritable and unpredictable.

(b) **Class 2**: minimal (20%), mild (29%), or moderate (38%) when one or more of the following is established:

Perception: Workers in this state have fairly serious problems in understanding their personal surroundings. They cannot be counted on to understand the difference between daydreams, imagination, and reality. They may have fantasies involving money or power, but they recognize them as fantasies. Because persons in this state are likely to be overly excited or suffering from paranoia, they are also likely to be domineering, peremptory, irritable, or suspicious.

Thinking process: The thinking process is so disturbed that persons in this state might not realize they are having mental problems. The problems might include (but are not limited to) obsessions, blocking, memory loss serious enough to affect work and personal life, confusion, powerful daydreams or long periods of being deeply lost in thought to no set purpose.

Social behavior: Persons in this state can control their social behavior if they are asked to do so. However, if left on their own, their behavior is so bizarre that others may be concerned. Such behavior might include (but is not limited to) over-activity, disarranged clothing, and talk or gestures which neither make sense nor fit the situation.

Emotional control: Persons in this state suffer a serious loss of control over their emotions. They may become extremely angry for little or no reason, they may cry easily, or they may have an extreme feeling of well-being, causing them to talk too much and to little purpose. These behaviors interfere with living and work and cause concern in others.

(c) **Class 3**: minimal (50%), mild (63%), or moderate (75%) when one or more of the following is established:

Perception: Workers in this state suffer from frequent illusions and hallucinations. Following the demands of these illusions and hallucinations leads to bizarre and disruptive behavior.

Thinking process: Workers in this state suffer from disturbances in thought that are obvious even to a casual observer. These include an inability to communicate clearly because of slurred speech, rambling speech, primitive language, and an absence of the ability to understand the self or the nature of the problem. Such workers also show poor judgment and openly talk about delusions without recognizing them as such.

Social behavior: Persons in this state are a nuisance or a danger to others. Actions might include interfering with work and other activities, shouting, sudden inappropriate bursts of profanity, carelessness about excretory functions, threatening others, and endangering others.

Emotional control: Workers in this state cannot control their personal behavior. They might be very irritable and overactive or so depressed they become suicidal.

(d) **Class 4**: 90% for workers who usually need to be placed in a hospital or institution. Medication may help them to a certain extent and the following is established:

Perception: Workers become so obsessed with hallucinations, illusions, and delusions that normal self-care is not possible. Bursts of violence may occur.

Thinking process: Communication is either very difficult or impossible. The worker is responding almost entirely to delusions, illusions, and hallucinations. Evidence of disturbed mental processes may include (but are not limited to) severe confusion, incoherence, irrelevance, refusal to speak, the creation of new words or using existing words in a new manner.

Social behavior: The worker's personal behavior endangers both the worker and others. Poor perceptions, confused thinking, lack of emotional control, and obsessive reaction to hallucinations, illusions, and delusions produce behavior that can result in the worker being inaccessible, suicidal, openly aggressive and assaultive, or even homicidal.

Emotional control: The worker may have either a severe emotional disturbance in which the worker is delirious and uncontrolled or extreme depression in which the worker is silent, hostile, and self-destructive. In either case, lack of control over anger and rage might result in homicidal behavior.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0410 Hematopoietic System

(1) Anemia can be impairing when the cardiovascular system cannot compensate for the effects of the anemia. The following values are given for workers who become anemic:

(a) **Class 1**: 0% when there are no complaints or evidence of disease and the usual activities of daily living can be performed; no blood transfusion is required; and the hemoglobin level is 10-12gm/100ml.

(b) **Class 2**: 30% when there are complaints or evidence of disease and the usual activities of daily living can be performed with some difficulty; no blood transfusion is required; and the hemoglobin level is 8-10gm/100ml.

(c) **Class 3**: 70% when there are signs and symptoms of disease and the usual activities of daily living can be performed with difficulty and with varying amounts of assistance from others; blood transfusion of 2 to 3 units is required every 4 to 6 weeks; and the hemoglobin level is 5-8gm/100ml before transfusion.

(d) **Class 4**: 85% when there are signs and symptoms of disease and the usual activities of daily living cannot be performed without assistance from others; blood transfusion of 2 to 3 units is required every 2 weeks, implying hemolysis of transfused blood; and the hemoglobin level is 5-8gm/100ml before transfusion.

(2) White blood cell system impairments are rated under the following classes:

(a) **Class 1**: 5% when there are symptoms or signs of leukocyte abnormality and no or infrequent treatment is needed and all or most of the activities of daily living can be performed.

(b) **Class 2**: 20% when there are symptoms and signs of leukocyte abnormality and continuous treatment is needed but most of the activities of daily living can be performed.

(c) **Class 3**: 40% when there are symptoms and signs of leukocyte abnormality and continuous treatment is needed and the activities of daily living can be performed with occasional assistance from others.

(d) **Class 4**: 73% when there are symptoms and signs of leukocyte abnormality and continuous treatment is needed and continuous care is required for activities of daily living.

(3) Splenectomy is given an impairment value of 5%.

(4) Hemorrhagic disorders receive 5% impairment if many activities must be avoided and constant endocrine therapy is needed, or anticoagulant treatment with a vitamin K antagonist is required. Hemorrhagic disorders that stem from damage to other organs or body systems are not rated under this section but are rated based on the impairment of the other organ or body system.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0420 Gastrointestinal and Genitourinary Systems

(1) Impairments in mastication (chewing) and deglutition (swallowing) are determined based on the following criteria:

(a) Diet limited to semi-solid or soft foods 8%

(b) Diet limited to liquid foods 25%

(c) Eating requires tube feeding or gastrostomy 50%

(2) Impairment of the upper digestive tract (esophagus, stomach and duodenum, small intestine, pancreas) is valued under the following classes:

Class 1 (3% Impairment)

Symptoms or signs of upper digestive tract disease are present or there is anatomic loss or alteration; and

Continuous treatment is not required; and

Weight can be maintained at the desirable level; or

There are no sequelae after surgical procedures.

Class 2 (15% Impairment)

Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and

Appropriate dietary restrictions and drugs are required for control of symptoms, signs or nutritional deficiency; and

Loss of weight below the "desirable weight"* does not exceed 10%.

Class 3 (35% Impairment)

Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and

Appropriate dietary restrictions and drugs do not completely control symptoms, signs, or nutritional state; or

There is 10-20% loss of weight below the "desirable weight"* which is ascribable to a disorder of the upper digestive tract.

Class 4 (63% Impairment)

Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and

Symptoms are not controlled by treatment; or

There is greater than a 20% loss of weight below the "desirable weight"* which is ascribable to a disorder of the upper digestive tract.

*Desirable weight table:

Desirable weights by sex, height, and body build

The weight charts include 5 lb clothing for men, 3 lb clothing for women, and shoes with 1" heels for both.

Men

Height (inches)	Weight (pounds) Small frame	Weight (pounds) Medium frame	Weight (pounds) Large frame
62	128-134	131-141	138-150
63	130-136	133-143	140-153
64	132-138	135-145	142-156
65	134-140	137-148	144-160
66	136-142	139-151	146-164
67	138-145	142-154	149-168
68	140-148	145-157	152-172
69	142-151	148-160	155-176
70	144-154	151-163	158-180
71	146-157	154-166	161-184
72	149-160	157-170	164-188
73	152-164	160-174	168-192
74	155-168	164-178	172-197
75	158-172	167-182	176-202
76	162-176	171-187	181-207

Women

Height (inches)	Weight (pounds) Small frame	Weight (pounds) Medium frame	Weight (pounds) Large frame
58	102-111	109-121	118-131
59	103-113	111-123	120-134
60	104-115	113-126	122-137
61	106-118	115-129	125-140
62	108-121	118-132	128-143
63	111-124	121-135	131-147
64	114-127	124-138	134-151
65	117-130	127-141	137-155
66	120-133	130-144	140-159
67	123-136	133-147	143-163
68	126-139	136-150	146-167
69	129-142	139-153	149-170
70	132-145	142-156	152-173
71	135-148	145-159	155-176
72	138-151	148-162	158-179

(3) Colonic and rectal impairment is rated under the following classes:

Class 1 (3% Impairment)

Signs and symptoms of colonic or rectal disease are infrequent and of brief duration; and

Limitation of activities, special diet or medication is not required; and

No systemic manifestations are present and weight and nutritional state can be maintained at a desirable level; or

There are no sequelae after surgical procedures.

Class 2 (15% Impairment)

There is objective evidence of colonic or rectal disease or anatomic loss or alteration; and

There are mild gastrointestinal symptoms with occasional disturbances of bowel function, accompanied by moderate pain; and

Minimal restriction of diet or mild symptomatic therapy may be necessary; and

No impairment of nutrition results.

Class 3 (30% Impairment)

There is objective evidence of colonic or rectal disease or anatomic loss or alteration; and

There are moderate to severe exacerbations with disturbance of bowel habit, accompanied by periodic or continual pain; and

Restriction of activity, special diet and drugs are required during attacks; and

There are constitutional manifestations (fever, anemia, or weight loss).

Class 4 (50% Impairment)

There is objective evidence of colonic and rectal disease or anatomic loss or alteration; and

There are persistent disturbances of bowel function present at rest with severe persistent pain; and

Complete limitation of activity, continued restriction of diet, and medication do not entirely control the symptoms; and

There are constitutional manifestations (fever, weight loss, or anemia) present.

(4) Anal impairment is rated under the following classes:

Class 1 (3% Impairment)

Signs of organic anal disease are present or there is anatomic loss or alteration; or

There is mild incontinence involving gas or liquid stool; or

Anal symptoms are mild, intermittent, and controlled by treatment.

Class 2 (13% Impairment)

Signs of organic anal disease are present or there is anatomic loss or alteration; and

Moderate but partial fecal incontinence is present requiring continual treatment; or

Continual anal symptoms are present and incompletely controlled by treatment.

Class 3 (23% Impairment)

Signs of organic anal disease are present and there is anatomic loss or alteration; and

Complete fecal incontinence is present; or

Signs of organic anal disease are present and severe anal symptoms unresponsive or not amenable to therapy are present.

(5) Liver impairment is determined under the following classes:

Class 1 (5% Impairment)

There is objective evidence of persistent liver disease even though no symptoms of liver disease are present; and no history of ascites, jaundice, or bleeding esophageal varices within three years; and

Nutrition and strength are good;

Biochemical studies indicate minimal disturbance in liver function; or

Primary disorders of bilirubin metabolism are present.

Class 2 (20% Impairment)

There is objective evidence of chronic liver disease even though no symptoms of liver disease are present; and no history of ascites, jaundice, or bleeding esophageal varices within three years; and

Nutrition and strength are good; and

Biochemical studies indicate more severe liver damage than Class 1.

Class 3 (40% Impairment)

There is objective evidence of progressive chronic liver disease, or history of jaundice, ascites, or bleeding esophageal or gastric varices within the past year; and

Nutrition and strength may be affected; or

There is intermittent hepatic encephalopathy.

Class 4 (75% Impairment)

There is objective evidence of progressive chronic liver disease, or persistent ascites or persistent jaundice or bleeding esophageal or gastric varices, with central nervous system manifestations of hepatic insufficiency; and

Nutritional state is poor.

Note: For successful liver transplants a basic impairment value of 50% of the digestive system is given. This is combined with any other impairments of the digestive system.

(6) Biliary tract impairment is determined under the following classes:

(a) **Class 1**: 5% for an occasional episode of biliary tract dysfunction.

(b) **Class 2**: 20% for recurrent biliary tract impairment irrespective of treatment.

(c) **Class 3**: 40% for irreparable obstruction of the bile tract with recurrent cholangitis.

(d) **Class 4**: 75% for persistent jaundice and progressive liver disease due to obstruction of the common bile duct.

(7) Impairment of the upper urinary tract is determined under the following classes:

Class 1 (5% Impairment)

Diminution of upper urinary tract function is present as evidenced by creatinine clearance of 75 to 90 liters/ 24 hr (52 to 62.5 ml/min), or PSP excretion of 15% to 20% in 15 minutes; or

Intermittent symptoms and signs of upper urinary tract dysfunction are present that do not require continuous treatment or surveillance.

Class 2 (23% Impairment)

Diminution of upper urinary tract function is present as evidenced by creatinine clearance of 60 to 75 liters/24 hr (42 to 52 ml/min), or PSP excretion of 10% to 15% in 15 minutes; or

Although creatinine clearance is greater than 75 liters/24 hr (52 ml/min), or PSP excretion is more than 15% in 15 minutes, symptoms and signs of upper urinary tract disease or dysfunction necessitate continuous surveillance and frequent treatment.

Class 3 (48% Impairment)

Diminution of upper urinary tract function is present as evidenced by creatinine clearance of 40 to 60 liters/24 hr (28 to 42 ml/min), or PSP excretion of 5% to 10% in 15 minutes; or

Although creatinine clearance is 60 to 75 liters/24 hr (42 to 52 ml/min), or PSP excretion is 10% to 15% in 15 minutes, symptoms and signs of upper urinary tract disease or dysfunction are incompletely controlled by surgical or continuous medical treatment.

Class 4 (78% Impairment)

Diminution of upper urinary tract function is present as evidenced by creatinine clearance below 40 liters/24 hr (28 ml/min), or PSP excretion below 5% in 15 minutes; or

Although creatinine clearance is 40 to 60 liters/24 hr (28 to 42 ml/min), or PSP excretion is 5% to 10% in 15 minutes, symptoms and signs of upper urinary tract disease or dysfunction persist despite surgical or continuous medical treatment.

*Note: The individual with a nephrectomy, as a result of an occupational injury or disease, should be rated as having 10% impairment. This value is to be combined with any other permanent impairment (including any impairment in the remaining kidney) pertinent to the case under consideration. The normal ranges of creatinine clearance are: Males: 130 to 200 liters/24 hr (90 to 139 ml/min). Females: 115 to 180 liters/24 hr (80 to 125 ml/min). The normal PSP excretion is 25% or more in urine in 15 minutes.

Permanent, surgically-created forms of urinary diversion usually are provided to compensate for anatomic loss and to allow for egress of urine. They are evaluated as a part of, and in conjunction with, the assessment of the involved portion of the urinary tract.

Irrespective of how well these diversions function in the preservation of renal integrity and the disposition of urine, the following values for the diversions should be combined with

those determined under the criteria previously given for the portion of the urinary tract involved:

Type of Diversion	% Impairment
Uretero-intestinal	10
Cutaneous ureterostomy without intubation	10
Nephrostomy or intubated ureterostomy	15

(8) Impairment of the bladder: When evaluating permanent impairment of the bladder, the status of the upper urinary tract must also be considered. The appropriate impairment values for both are combined under OAR 436-035-0011(5). Impairment of the bladder is determined under the following classes:

(a) **Class 1**: 5% when the patient has symptoms and signs of bladder disorder requiring intermittent treatment with normal function between episodes of malfunction.

(b) **Class 2**: 18% when (a) there are symptoms or signs of bladder disorder requiring continuous treatment; OR (b) there is good bladder reflex activity, but no voluntary control.

(c) **Class 3**: 30% when the bladder has poor reflex activity, that is, there is intermittent dribbling, and no voluntary control.

(d) **Class 4**: 50% when there is no reflex or voluntary control of the bladder, that is, there is continuous dribbling.

(9) Urethra: When evaluating permanent impairment of the urethra, one must also consider the status of the upper urinary tract and bladder. The values for all parts of the urinary system are combined under OAR 436-035-0011(5). Impairment of the urethra is determined under the following classes:

(a) **Class 1**: 3% when symptoms and signs of urethral disorder are present that require intermittent therapy for control.

(b) **Class 2**: 15% when there are symptoms and signs of a urethral disorder that cannot be effectively controlled by treatment.

(10) Penile sexual dysfunction: When evaluating permanent impairment due to sexual dysfunction of the penis, one must also consider the status of the urethra upper urinary tract and bladder. The values for all parts of the system are combined under OAR 436-035-0011(6). Loss or alteration of the gonads is valued under OAR 436-035-0430. Impairment due to sexual dysfunction of the penis is determined under the following classes:

Class 1
(Under 40 years old = 12% 40-65 years old = 8% Over 65 years old = 4%)

Sexual function is possible, but with varying degrees of difficulty of erection, ejaculation or sensation.

Class 2
(Under 40 years old = 21% 40-65 years old = 14% Over 65 years old = 7%)

Sexual function is possible with sufficient erection, but with impaired ejaculation and sensation.

Class 3
(Under 40 years old = 30% 40-65 years old = 20% Over 65 years old = 10%)

No sexual function is possible.

(11) Cervix/uterus/vagina: When evaluating permanent impairment of the cervix/uterus/vagina, one must also consider the status of the urethra, upper urinary tract and bladder. The values for all parts of the system are combined under OAR 436-035-0011(5). Loss or alteration of the gonads is valued under OAR 436-035-0430. Impairment of the cervix/uterus/vagina is determined under the following classes:

Class 1 (8% Impairment)

Symptoms and signs of disease or deformity of the cervix, uterus, or vagina are present that do not require continuous treatment; or

Cervical stenosis, if present, requires no treatment; or

There is anatomic loss of the cervix, uterus, or vagina in the postmenopausal years.

Class 2 (20% Impairment)

Symptoms and signs of disease or deformity of the cervix, uterus, or vagina are present that require continuous treatment; or

Cervical stenosis, if present, requires periodic treatment.

Class 3 (32% Impairment)

Symptoms and signs of disease or deformity of the cervix, uterus, or vagina are present that are not controlled by treatment; or

Cervical stenosis is complete; or

Anatomic or complete functional loss of the cervix, uterus, or vagina in premenopausal years.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0430 Endocrine System

(1) The assessment of permanent impairment from disorders of the hypothalamic-pituitary axis requires evaluation of (1) primary abnormalities related to growth hormone, prolactin, or ADH; (2) secondary abnormalities in other endocrine glands, such as thyroid, adrenal, and gonads, and; (3) structural and functional disorders of the central nervous system caused by anatomic abnormalities of the pituitary. Each disorder must be evaluated separately, using the standards for rating the nervous system, visual system, and mental and behavioral disorders, and the impairments combined. Impairment of the hypothalamic-pituitary axis is determined under the following classes:

(a) **Class 1**: 5% when controlled effectively with continuous treatment.

(b) **Class 2**: 18% when inadequately controlled by treatment.

(c) **Class 3**: 38% when there are severe symptoms and signs despite treatment.

(2) Impairment of thyroid function results in either hyperthyroidism or hypothyroidism. Hyperthyroidism is not considered to be a cause of permanent impairment, because the hypermetabolic state in practically all patients can be corrected permanently by treatment. After remission of hyperthyroidism, there may be permanent impairment of the visual or cardiovascular systems, which should be evaluated using the appropriate standards for those systems.

Hypothyroidism in most instances can be satisfactorily controlled by the administration of thyroid medication. Occasionally, because of associated disease in other organ systems, full hormone replacement may not be possible. Impairment of thyroid function is determined under the following classes:

(a) **Class 1**: 5% when (a) continuous thyroid therapy is required for correction of the thyroid insufficiency or for maintenance of normal thyroid anatomy; AND (b) the replacement therapy appears adequate based on objective physical or laboratory evidence.

(b) **Class 2**: 18% when (a) symptoms and signs of thyroid disease are present, or there is anatomic loss or alteration; AND (b) continuous thyroid hormone replacement therapy is required for correction of the confirmed thyroid insufficiency; BUT (c) the presence of a disease process in another body system or systems permits only partial replacement of the thyroid hormone.

(3) Parathyroid: Impairment of parathyroid function results in either hyperparathyroidism or hypoparathyroidism.

(a) In most cases of hyperparathyroidism, surgical treatment results in correction of the primary abnormality, although secondary symptoms and signs may persist, such as renal calculi or renal failure, which should be evaluated under the appropriate standards. If surgery fails, or cannot be done, the patient may require long-term therapy, in which case the permanent impairment may be classified under the following:

(A) **Class 1**: 5% when symptoms and signs are controlled with medical therapy.

(B) **Class 2**: 18% when there is persistent mild hypercalcemia, with mild nausea and polyuria.

(C) **Class 3**: 78% when there is severe hypercalcemia, with nausea and lethargy.

(b) Hypoparathyroidism is a chronic condition of variable severity that requires long-term medical therapy in most cases. The severity determines the degree of permanent impairment under the following:

(A) **Class 1**: 3% when symptoms and signs controlled with medical therapy.

(B) **Class 2**: 15% when intermittent hypercalcemia or hypocalcemia, and more frequent symptoms in spite of careful medical attention.

(4) Adrenal cortex: Impairment of the adrenal cortex results in either hypoadrenalism or hyperadrenocorticism.

(a) Hypoadrenalism is a lifelong condition that requires long-term replacement therapy with glucocorticoids or mineralocorticoids for proven hormonal deficiencies. Impairments are rated as follows:

(A) **Class 1**: 5% when symptoms and signs are controlled with medical therapy.

(B) **Class 2**: 33% when symptoms and signs are controlled inadequately, usually during the course of acute illnesses.

(C) **Class 3**: 78% when severe symptoms of adrenal crisis during major illness, usually due to severe glucocortocoid deficiency or sodium depletion.

(b) Hyperadrenocorticism due to the chronic side effects of nonphysiologic doses of glucocorticoids (iatrogenic Cushing's syndrome) is related to dosage and duration of treatment and includes osteoporosis, hypertension, diabetes mellitus and the effects involving catabolism that result in protein myopathy, striae, and easy bruising. Permanent impairment ranges from 5% to 78%, depending on the severity and chronicity of the disease process for which the steroids are given. On the other hand, with diseases of the pituitary-adrenal axis, impairment may be classified based on severity:

(A) **Class 1**: 5% when minimal, as with hyperadrenocorticism that is surgically correctable by removal of a pituitary or adrenal adenoma.

(B) **Class 2**: 33% when moderate, as with bilateral hyperplasia that is treated with medical therapy or adrenalectomy.

(C) **Class 3**: 78% when severe, as with aggressively metastasizing adrenal carcinoma.

(5) Adrenal medulla: Impairment of the adrenal medulla results from pheochromocytoma and is classified as follows:

(a) **Class 1**: 5% when the duration of hypertension has not led to cardiovascular disease and a benign tumor can be removed surgically.

(b) **Class 2**: 33% when there is inoperable malignant pheochromocytomas, if signs and symptoms of catecholoamine excess can be controlled with blocking agents.

(c) **Class 3**: 78% when there is wide metastatic malignant pheochromocytomas, in which symptoms of catecholamine excess cannot be controlled.

(6) Pancreas: Impairment of the pancreas results in either diabetes mellitus or in hypoglycemia.

(a) Diabetes mellitus is rated under the following classes:

(A) **Class 1**: 3% when non-insulin dependent (Type II) diabetes mellitus can be controlled by diet; there may or may not be evidence of diabetic microangiopathy, as indicated by the presence of retinopathy or albuminuria greater than 30 mg/100 ml.

(B) **Class 2**: 8% when non-insulin dependent (Type II) diabetes mellitus; and satisfactory control of the plasma glucose requires both a restricted diet and hypoglycemic

medication, either an oral agent or insulin. Evidence of microangiopathy, as indicated by retinopathy or by albuminuria of greater than 30 mg/100 ml, may or may not be present.

(C) **Class 3**: 18% when insulin dependent (Type I) diabetes mellitus is present with or without evidence of microangiopathy.

(D) **Class 4**: 33% when insulin dependent (Type I) diabetes mellitus, and hyperglycemic or hypoglycemic episodes occur frequently in spite of conscientious efforts of both the patient and the attending physician.

(b) Hypoglycemia is rated under the following classes:

(A) **Class 1**: 0% when surgical removal of an islet-cell adenoma results in complete remission of the symptoms and signs of hypoglycemia, and there are no post-operative sequelae.

(B) **Class 2**: 28% when signs and symptoms of hypoglycemia are present, with controlled diet and medications and with effects on the performance of activities of daily living.

(7) Gonadal hormones: A patient with anatomic loss or alteration of the gonads that results in a loss or alteration in the ability to produce and regulate the gonadal hormones receives a value of 3% impairment for unilateral loss or alteration and 5% for bilateral loss or alteration. Loss of the cervix/uterus or penile sexual function is valued under OAR 436-035-0420.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0440 Integument and Lacrimal System

(1) If the worker has developed an immunologic reaction to physical, chemical or biological agents, impairment will also be valued under OAR 436-035-0450.

(2) Impairments of the integumentary system may or may not show signs or symptoms of skin disorder upon examination but are rated under the following classes:

(a) **Class 1**: 3% when with treatment, there is no limitation, or minimal limitation, in the performance of work related activities, although exposure to certain physical or chemical agents might increase limitation temporarily.

(b) **Class 2**: 15% when intermittent treatment is required and there is mild limitation in the performance of some work related activities.

(c) **Class 3**: 38% when continuous treatment is required and there is moderate limitation in the performance of many work related activities.

(d) **Class 4**: 68% when continuous treatment is required, which may include periodic confinement at home or other domicile; and there is moderate to severe limitation in the performance of many work related activities.

(e) **Class 5**: 90% when continuous treatment is required, which necessitates confinement at home or other domicile; and there is severe limitation in the performance of work related activities.

(3) If either too little or too much tearing results in a worker's being restricted from regular work, and the condition is not an immunological reaction, a value is assigned as follows:

(a) **Class 1**: 3% when the reaction is a nuisance but does not prevent most regular work-related activities; or

(b) **Class 2**: 8% when the reaction prevents some regular work-related activities; or

(c) **Class 3**: 13% when the reaction prevents most regular work-related activities.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0450 Immune System

(1) When exposure to physical, chemical, or biological agents has resulted in the development of an immunological response, impairment of the immune system is valued as follows:

(a) **Class 1**: 3% when the reaction is a nuisance but does not prevent most regular work related activities.

(b) **Class 2**: 8% when the reaction prevents some regular work related activities.

(c) **Class 3**: 13% when the reaction prevents most regular work related activities.

(2) An allergy is considered to be an immunologic state and is ratable under this rule.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-035-0500 Rating Standard for Individual Claims

(1) This rule applies to the rating of permanent disability under ORS chapter 656 in individual cases under ORS 656.726(4)(f) which requires the director to determine the rating standard in cases where the director finds that the worker's impairment is not addressed in the disability standards.

(2) Rating standards determined under ORS 656.726(4)(f) will be written into the director's order on reconsideration and will apply solely to the rating of that claim.

Stat. Auth.: ORS 656.726(3), (§7, ch. 270, OL 2007)
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726 (§7, ch. 270, OL 2007)
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 040

WORKERS WITH DISABILITIES PROGRAM

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436-040-0001 Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.726 and 656.628.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628
Hist.: WCD 6-1983(Admin), f. 12-20-83, ef. 1-1-84

436-040-0002 Purpose

The purpose of these rules is to establish guidelines for the administration of the Workers with Disabilities Program established to encourage the employment or reemployment of workers with disabilities.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-040-0003 Applicability of Rules

(1) These rules are effective July 1, 2008, and apply to all applications for relief submitted prior to May 1, 1990 and all requests for reimbursement from the Workers with Disabilities Program filed with the director on or after July 1, 2008 for injuries occurring on or after November 1, 1981.

(2) These rules carry out the provisions of ORS 656.628.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 6/12/08 as WCD Admin. Order 08-055, eff. 7/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-040-0005 Definitions

Except where the context requires otherwise, these rules are governed by the following definitions:

(1) "Compensation" means all benefits, including medical services and attorney fees, provided for a compensable injury to a subject worker or the worker's beneficiaries. However, it does not include expenses as defined by the National Council on Compensation Insurance, in its Workers' Compensation Statistical Plan, Part IV.

(2) "Deductible" means the initial $1,000 of cumulative compensation paid on qualifying claim(s) applied once per worker with a disability.

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

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

(5) "Employer" means an employer who qualifies pursuant to the provisions of ORS 656.017, either as a carrier-insured employer or as a self-insured employer under ORS 656.407.

(6) " Worker with a disability" means a worker who is afflicted with, or subject to, any permanent physical or mental impairment, whether congenital or due to an injury or disease, including periodic impairment of consciousness or muscular control of such character that the impairment would prevent the worker from obtaining or retaining employment.

(7) " Workers with Disabilities Claim Reserve" means the total anticipated liability (paid plus future reimbursable costs) regardless of any relief granted under the Workers with Disabilities Program.

(8) " Workers with Disabilities Program" means the program established under ORS 656.628.

(9) "Paying Agency" means the insurer, self-insured employer, or designated representative of the self-insured employer, responsible for paying compensation for a compensable injury.

(10) "Settlement" means any agreement produced as a result of the act or process of settling differences between a paying agent and a worker with a disability, or disposition of a claim pursuant to ORS 656.236 or 656.289.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-040-0006 Administration of Rules

For the purpose of administration of the Workers with Disabilities Program, orders of the division are deemed orders of the director.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-040-0008 Administrative Review

(1) If a paying agency or employer is aggrieved by a decision of the division, the director may be petitioned for reconsideration.

(2) The director shall examine the application and such further evidence filed, and enter an order. Copies of the order

will be sent to the paying agency, the division, and employer, if applicable. Granting or denying reimbursement from the Workers with Disabilities Program is at the sole discretion of the director. Pursuant to ORS 656.628(7), the director's order is final and not subject to review by any court or other administrative body.

(3) In adopting these rules, the director reserves the right to reexamine any liability created against the Workers' Benefit Fund and to modify or terminate such liability, where such action is justified.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-040-0010 Criteria for Eligibility

(1) The criteria used to determine eligibility for relief from the Workers with Disabilities Program are:

(a) Without regard to employer knowledge, a worker must have a permanent physical or mental impairment, whether congenital or due to an injury or disease which would prevent the worker from obtaining or retaining employment. For the purpose of this section, a worker has a preexisting permanent impairment if it is equal to or greater than twenty five percent (25%) of the whole person.

(b) There must be a subsequent compensable injury or injuries:

(A) To the worker with a disability resulting in cumulative claim(s) costs in excess of $1,000; or

(B) To other workers employed by the disabled worker's employer resulting in cumulative claim(s) costs in excess of $1,000.

(c) The insurer or employer must demonstrate that the subsequent injury or injuries:

(A) Would not have been sustained except for the disabled worker's impairment; or

(B) Would not have occurred, to workers of the same employer, except for the act or omission of a worker with a disability which resulted from the disabled worker's impairment; or

(C) Resulted in disability which is at least one-fourth greater by reason of the worker's preexisting impairment, as determined by the division.

(2) An employer declared noncomplying in accordance with ORS 656.052 is not eligible for relief from the Workers with Disabilities Program for injuries to subject workers occurring during any period of noncompliance.

(3) A paying agency is not eligible for reimbursement from the Workers with Disabilities Program for any claim occurring to a worker during a period for which the employer is receiving premium reimbursement from the Reemployment Assistance Program, for that worker, pursuant to ORS 656.622(3).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-040-0020 Limitation of Program

(1) Reimbursement is limited to the monies available in the Workers' Benefit Fund.

(2) In the event of insufficient reserves in the Workers' Benefit Fund, the director shall have final authority to determine an equitable distribution which will proportionately distribute the available funds among the claims which have qualified for reimbursement from the Workers with Disabilities Program.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-040-0030 Application for Determination of Relief From the Workers with Disabilities Program

(1) The paying agency must provide the director adequate evidence to establish eligibility for determination of relief from the Workers with Disabilities Program.

(2) When the deductible has been met and possible eligibility for relief becomes known, the paying agency shall make prompt application to the division requesting determination of relief from the Workers with Disabilities Program in a form prescribed by the director.

(3) The application shall be submitted prior to the date of the last valuation affecting an employer's experience rating, prior to the last valuation for retrospective rating, whichever is the last to occur and prior to the employer ceasing to do business. The application shall be supported by sufficient evidence establishing eligibility for reimbursement under the general provisions herein and in accordance with OAR 436-040-0010. For employers that are not experience rated, application shall be submitted prior to the date there would have been a last valuation, had the employer been so rated, and prior to the employer ceasing to do business. The preceding application time frames do not apply to self-insured employers or their paying agencies.

(4) To meet the requirements of OAR 436-040-0030(3), the paying agency shall:

(a) Specify the condition which caused permanent impairment and which constituted a handicap;

(b) Specify whether this request is based on a causal or contributory relationship pursuant to OAR 436-040-0010(1)(c);

(c) Provide documentation describing prior impairment: such as medical reports, direct information from the worker, employer documentation, prior Determination Orders, Opinion and Orders, and Orders on Review;

(5) The division will review the application to assure it is complete and the $1,000 deductible has been met. The application, supporting documentation, and claims involved will then be submitted to the division for an eligibility determination.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-040-0040 Eligibility Determination

(1) The division shall determine whether a claim qualifies for reimbursement, and the percentage of the reimbursement.

(2) The division shall issue a determination order accepting or denying the application within 30 calendar days after receipt of the application and supporting documentation.

(3) The reimbursement percentage shown on the determination order will be:

(a) 100% after the $1,000 deductible in those cases qualifying under OAR 436-040-0010(1)(c)(A) and (B); or

(b) In direct proportion to the percentage the resulting disability was increased as a result of the preexisting impairment in those cases qualifying under OAR 436-040-0010(1)(c)(C).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-040-0050 Reimbursement

(1) Reimbursement will be made to the paying agency based on the percentage of reimbursement ordered by the division.

(2) Request for reimbursement shall not be made until the deductible has been met.

(3) Requests for reimbursement are not to include: costs incurred for conditions unrelated to the compensable claim; costs incurred due to inaccurate, untimely, or improper processing; expenses; and settlement amounts not approved by the division, to which the parties agreed after relief was granted.

(4) The division will authorize reimbursement to the paying agency quarterly after receipt and approval of documentation of compensation paid from the paying agency. Documentation shall include, but not be limited to:

(a) Net amounts paid separated into disability benefits by type, and medical benefits for corresponding quarterly time periods;

(b) The current Worker with a Disability Claim Reserve as defined in these rules;

(c) Payment certification statement; and

(d) Any other information deemed necessary by the director.

(5) For purposes of subsection 4(a) of this rule, "net amounts paid" means the total compensation paid less any recoveries, including but not limited to, third party recovery, Retroactive Program reimbursement and Rehabilitation Program reimbursement.

(6) Periodically the division will audit the physical file of the paying agency to validate the amount reimbursed. Reimbursement shall not be approved if, upon such audit, any of the following are found to apply:

(a) Compensation has been paid as a result of untimely, inaccurate, or improper claims processing;

(b) Compensation has been paid for treatment of any condition unrelated to the compensable claim for which Workers with Disabilities Program relief was granted.

(c) The compensability of the accepted claim is questionable and the rationale for acceptance has not been reasonably documented, as required under generally accepted claims management procedures;

(d) The separate payments of compensation have not been documented, as required under generally accepted accounting procedures;

(e) For applications received after January 1, 1990, the subject employer was no longer doing business at the time of application for the Workers with Disabilities Program determination; that the employer was on a retrospective rating plan that was closed prior to the application for the Workers with Disabilities Program determination; or, if not on an open retrospective rating plan, that the last valuation for experience rating modification purposes that could affect the employer was completed prior to the application for the Workers with Disabilities Program determination;

(f) The insurer did not adjust the claims reserve value used in dividend, retrospective evaluation, or any claim valuation for experience rating determination to the percentage level specified in the order of acceptance, allowing for the $1,000 compensation minimum, or did not make the necessary monetary adjustments with the employer; or

(g) The insurance carrier is not able to provide applicable records relating to experience rating, retrospective rating or dividend calculations at the time of audit or within ten working days thereafter. Any reimbursements received on claims, for which the insurer is unable to provide records, will be returned to the division at least until the next annual audit is conducted and all applicable records are reviewed.

(7) The division will authorize reimbursement to insurance companies only for compensation which could reasonably be projected at the first of either to occur;

(a) The last claim evaluation which would affect the employer's experience rating modification or retrospective rating adjustment, whichever is later; or

(b) For applications received after January 1, 1990, the employer ceases to do business, if that occurs first.

(8) The insurance company shall submit a claim valuation to the division at the first to occur of:

(a) The last claim valuation date which would affect the employer's experience rating modification or retrospective rating adjustment, whichever is later (usually three and one half years after the inception of the policy period); or

(b) For applications received after January 1, 1990, the employer ceases to do business. The valuation shall include future reserves for the claim at that time. The division will verify the future reserves are reasonable and based on the appropriate valuation date. If the division determines the submitted claim valuation is unreasonable or based on inappropriate information, the division may establish the claim valuation or adjust the claim valuation period. The claim valuation, when approved by the division, shall be the

maximum Worker with a Disability Claim Reserve used as the basis for reimbursement for the claim.

(9) When a claim is settled by a Compromise and Release or a Disputed Claims Settlement, the department shall review and modify the final reserve to reflect resulting changes in liability. The paying agent shall be notified of any change in the final reserve. A director review of this action will be considered only when paid claim costs have exceeded the established reserve.

(10) In the event that a denied claim is found compensable by a hearing referee, the Workers' Compensation Board, or the Court of Appeals, and that decision is reversed by a higher level of appeal, the paying agency shall receive reimbursement for claim payments required to be made while the claim was in accepted status.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-040-0060 Effects on Rates; Reporting

(1) Where an order of acceptance has established the percentage of reimbursement to an insured, the incurred claim cost above $1,000, prior to reimbursement, shall be reduced by that percentage. The net incurred cost after such reduction shall be used in any dividend calculation, retrospective rating evaluation or experience rating computation, retroactively if necessary, and shall be reported at that net incurred cost to the rating organization. Any subsequent reevaluation of the claims reserve requirements under the rules of the Unit Statistical Plan Manual shall be similarly reduced by the percentage of reimbursement.

(2) The paying agency "eligible for" or receiving reimbursement from the Workers with Disabilities Program, shall report the subject claims in such method and manner as the insurance commissioner shall require. Notwithstanding the reporting requirements of the Insurance Commissioner and an authorized rating organization, the paying agency must be able to document that such reimbursed costs are not and will not be included in data reported that will affect the rates and/or dividend eligibility.

(3) If compensation reported to the appropriate rating organization subsequently becomes eligible for reimbursement from the Workers with Disabilities Program, the insured paying agency shall immediately file a "reevaluation of losses" report, pursuant to the Insurance Commissioner's rules, with a rating organization licensed by the Insurance Commissioner.

(4) If compensation used by the division for experience rating purposes becomes eligible for reimbursement from the Workers with Disabilities Program, the self-insured paying agency may file a request for reevaluation of experience rating modification(s) with the division. Any necessary calculation(s) will be made, retroactively if necessary, when the annual experience rating modification is calculated.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-040-0070 Settlements

(1) Any settlement of the claim by the parties is not eligible for reimbursement from the Workers with Disabilities Program unless made with the prior written approval of the division.

(2) Requests for written approval of proposed settlements should include:

(a) A copy of the proposed settlement;

(b) Correspondence between the paying agency and the claimant or claimant's representative which establishes the basis for settlement or a statement from the paying agency of how the amount of the settlement was calculated;

(c) Additional medical reports not available at the time of the determination; and

(d) Other material which would support the proposed settlement as an appropriate manner to handle the claim.

(3) The paying agency shall submit settlements to the division in the format prescribed by the director.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-040-0080 Third Party Recoveries

(1) If a third party recovery is made prior to a claim qualifying for Workers with Disabilities Program relief, compensation recovered shall be credited against the compensation of the claim prior to any request for reimbursement.

(2) The Workers with Disabilities Program shall be a party to any third party recovery on a claim if payment from the program has been made prior to the third party recovery as provided in ORS 656.591 and ORS 656.593(1)(c).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-040-0090 Assessment of Civil Penalties

The director, through the division and pursuant to ORS 656.745, may assess a civil penalty against an insurer. When the division imposes a penalty under this section, the order shall be issued in accordance with ORS 656.447, ORS 656.704 and the contested case provisions of the Administrative Procedures Act (ORS Chapter 183).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 045

REOPENED CLAIMS PROGRAM

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436-045-0001 Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.625 and ORS 656.726.

Stat. Auth.: ORS 656.625 and ORS 656.726
Stats. Implemented: ORS 656.625
Hist.: Filed 12-18-87 as WCD Admin. Order 8-1987, eff. 1-1-88.

436-045-0002 Purpose

The purpose of these rules is to establish guidelines for administering disbursements made from the Reopened Claims Program established to reimburse compensation paid as a result of awards made by the Board or voluntary claim reopenings pursuant to ORS 656.278.

Stat. Auth.: ORS 656.625 and ORS 656.726
Stats. Implemented: ORS 656.625 & 656.726
Hist.: Amended 12/6/01 as WCD Admin. Order 01-062, eff. 1/1/02
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-045-0003 Applicability of Rules

(1) These rules are effective July 1, 2008, and apply to all requests for reimbursement from the Reopened Claims Program.

(2) These rules apply to all awards ordered on claims opened by the Board under ORS 656.278 on or after January 1, 1988 and all voluntary claim reopenings on or after January 1, 2002.

(3) These rules carry out the provisions of ORS 656.625.

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

Stat. Auth.: ORS 656.625
Stats. Implemented: ORS 656.236, 656.289, & 656.625
Hist.: Amended 6/12/08 as WCD Admin. Order 08-056, eff. 7/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-045-0005 Definitions

As used in OAR 436-045-0001 through 436-045-0030 unless the context requires otherwise:

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

(2) "Compensation" includes all benefits payable as a result of any order or award made by the Board or voluntary claim reopening pursuant to ORS 656.278.

(3) "Compliance" means the Compliance Section of the Workers' Compensation Division of the Department of Consumer and Business Services.

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

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

(6) "Disposition" or "claim disposition" means the written agreement executed by all parties in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794, except for medical services, in an accepted claim.

(7) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(8) "Paying Agency" means the insurer, self-insured employer, self-insured employer group or designated representative of the self-insured employer/group, responsible for paying compensation for a compensable injury.

(9) "Reopened Claims Program" and "Program" means the program established pursuant to ORS 656.625.

(10) "Voluntary Claim Reopening" means any claim reopened by the insurer or self-insured employer to provide benefits or to grant additional medical or hospital care to the claimant pursuant to ORS 656.278.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.726
Hist.: Amended 12/6/01 as WCD Admin. Order 01-062, eff. 1/1/02
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-045-0006 Administration of Rules

Any orders issued by the divisions in carrying out the director's authority to enforce ORS Chapter 656 and these rules are considered orders of the director.

Stat. Auth.: ORS 656.704 & 656.726
Stats. Implemented: ORS 656.704 & 656.726
Hist.: Amended 12/4/97 as WCD Admin. Order 97-061, eff. 1/1/98
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-045-0008 Administrative Review

(1) Any party as defined by ORS 656.005 aggrieved by a proposed order or proposed assessment of civil penalty of the director or division issued pursuant to ORS 656.745 or 656.750 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

(a) The request for hearing must be sent in writing to the Administrator of the Workers' Compensation Division. No hearing shall be granted unless the request specifies the grounds upon which the person requesting the hearing contests the proposed order or assessment.

(b) The request for hearing must be filed with the Administrator of the Workers' Compensation Division by the aggrieved person within 60 days after the mailing of the proposed order or assessment. No hearing shall be granted

unless the request is mailed or delivered to the administrator within 60 days after the mailing of the proposed order or assessment.

(2) Under ORS 656.704(2), any party that disagrees with an action or order of the director under these rules, other than as described in section (1), may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 656.704, 656.726(4), 656.745
Stats. Implemented: ORS 656.236, 656.289, 656.625, 656.704, OL 2005 ch 26, 656.726(8), 656.740, 656.745
Hist.: Amended 11/1/07 as WCD Admin. Order 07-062, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-045-0010 Criteria for Eligibility

(1) In order to qualify for reimbursement from the Reopened Claims Program there must be:

(a) An order or award issued by the Board upon its own motion pursuant to ORS 656.278 and as provided by OAR Chapter 438, Division 12 or a voluntary claim reopening; and

(b) Verifiable compensation paid in accordance with the order or award issued by the Board or voluntary claim reopening, including permanent disability awarded as a result of a reopening due to a new or omitted medical condition pursuant to ORS 656.278(1)(b).

(2) Notwithstanding paragraph (1)(b) of this rule, reimbursement may be made from the Program for reasonable overpayments of temporary disability. Reasonable overpayments are those made from the date a worker becomes medically stationary, returns to work or is released to work until the insurer is notified or should have known of the status change.

(3) Costs for claims to subject workers of an employer who is in a noncomplying status as defined in ORS 656.052 are not eligible for reimbursement from the Program but remains a cost recoverable from the employer as provided by ORS 656.054(3).

Stat. Auth.: ORS 656.625
Stats. Implemented: ORS 656.236, ORS 656.289 & 656.625
Hist.: Amended 12/6/01 as WCD Admin. Order 01-062, eff. 1/1/02
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-045-0020 Limitation of Program

(1) Reimbursement shall be limited to the monies available in the Workers' Benefit Fund.

(2) In the event of insufficient funds in the Workers' Benefit Fund, the director shall have final authority to determine an equitable distribution which will proportionately distribute the available funds among the claims having qualified for reimbursement under the Program.

Stat. Auth.: ORS 656.625
Stats. Implemented: ORS 656.625
Hist.: Amended 12/4/97 as WCD Admin. Order 97-061, eff. 1/1/98
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-045-0025 Dispositions

(1) In order for a disposition of a claim by the parties to be considered for reimbursement eligibility under the Reopened Claims Program, it must be submitted to the director during the period of time in which the claim remains open under the Board's Own Motion or voluntary claim reopening.

(2) Dispositions submitted in accordance with (1) are not eligible to receive reimbursement from the Reopened Claims Program unless made with the prior written approval of the director.

(3) Requests for written approval of proposed dispositions shall include:

(a) A copy of the proposed disposition which specifies the amount of the proposed contribution to be made from the Reopened Claims Program;

(b) A statement from the insurer indicating how the amount of the contribution was calculated;

(c) Any other information as required by the director.

(4) The director will not approve the disposition for reimbursement if the proposed contribution from the Program exceeds a reasonable projection of that claim's future liability to the Program under that Board's Own Motion reopening or voluntary claim reopening.

Stat. Auth.: ORS 656.236, 656.289, & 656.625
Stats. Implemented: ORS 656.236, 656.289 & 656.625
Hist.: Amended 12/6/01 as WCD Admin. Order 01-062, eff. 1/1/02
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-045-0030 Reimbursement

(1) Reimbursement shall be made by Compliance quarterly after receipt and approval of documentation of compensation paid by the paying agent.

(2) The director, by bulletin, shall prescribe the form and format for requesting reimbursement from the Program. Documentation to support the reimbursement request shall include but not be limited to:

(a) Net temporary disability compensation paid, net permanent disability paid, and net medical compensation paid for dates of injury prior to January 1, 1966. For purposes of this section, "net" compensation paid means the total compensation paid less any recoveries, including but not limited to, third party recovery, Retroactive Program reimbursement, and Workers with Disabilities Program reimbursement.

(b) Payment certification statement.

(c) Any other information deemed necessary by the director.

(3) Periodically Compliance shall audit the physical file of the paying agent to validate the amount reimbursed and to verify that the closing report is correct. Reimbursement shall not be approved if, upon such audit, it is found:

(a) Payments were not authorized in the Board's Own Motion order or voluntary claim reopening; or

(b) Payments of temporary disability compensation were made for periods of time during which the worker did not qualify as a "worker" pursuant to ORS 656.005(30); or

(c) Compensation has been paid as a result of untimely, inaccurate, or improper claims processing; or

(d) The separate payments of compensation have not been documented, as required under generally accepted accounting procedures; or

(e) Medical payments for claims with injury dates prior to January 1, 1966 are in excess of what should have been paid if paid in accordance with OAR 436-009-0030 and properly audited as required by OAR 436-009-0020; or

(f) Permanent disability payments were made in claims reopened for other than a new medical or omitted condition.

Stat. Auth.: ORS 656.625
Stats. Implemented: ORS 656.625
Hist.: Amended 11/1/07 as WCD Admin. Order 07-062, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 050

EMPLOYER/INSURER COVERAGE RESPONSIBILITY

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436-050-0001 Authority for Rules

These rules are adopted under the director's authority contained in ORS 656.407, 656.430, 656.455, 656.726, 656.850, 656.855, and 731.475.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.017, 656.018, 656.021, 656.023, 656.027, 656.029, 656.031, 656.037, 656.039, 656.126, 656.128, 656.140, 656.403, 656.407, 656.419, 656.423, 656.427, 656.430, 656.434, 656.440, 656.443, 656.447, 656.455, 656.614, 656.745, 656.750, 656.850, 656.855, and 731.475
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0002 Purpose

The purpose of these rules is to carry out the workers' compensation law related to employers' and insurers' responsibilities to cover subject workers for compensable injuries and illnesses.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.017
Hist:
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0003 Applicability of Rules

(1) These rules are effective Jan. 1, 2016, to carry out the provisions of:

(a) ORS 656.017 – Employer required to pay compensation and perform other duties.

(b) ORS 656.029 – Independent contractor status.

(c) ORS 656.126 – Coverage while temporarily in or out of state.

(d) ORS 656.407 – Qualifications of insured employers.

(e) ORS 656.419 – Workers' compensation insurance policies.

(f) ORS 656.423 – Cancellation of coverage by employer.

(g) ORS 656.427 – Cancellation of workers' compensation insurance policy or surety bond liability by insurer.

(h) ORS 656.430 – Certification of self-insured employer.

(i) ORS 656.434 – Certification effective until canceled or revoked; revocation of certificate.

(j) ORS 656.443 – Procedure upon default by employer.

(k) ORS 656.447 – Sanctions against insurer for failure to comply with orders, rules, or obligations under workers' compensation insurance policies.

(l) ORS 656.455 – Records location and inspection.

(m) ORS 656.745 – Civil penalties.

(n) ORS 656.850 and 656.855 – Worker leasing companies.

(o) ORS 731.475 – Insurer's in-state location.

(2) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.017, 656.029, 656.126, 656.407, 656.419, 656.423, 656.427, 656.430, 656.434, 656.443, 656.447, 656.455, 656.745, 656.850, 656.855, and 731.475
Hist: Amended 12/24/15 as WCD Admin. Order 15-067, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0005 Definitions

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

(1) "Audited financial statement" means a financial statement audited by an outside accounting firm.

(2) "Board" means the Workers' Compensation Board of the Department of Consumer and Business Services.

(3) "Cancel" or "cancellation" of coverage means ending a policy at a date before its expiration date.

(4) "Client" means a person to whom workers are provided under contract and for a fee on a temporary or leased basis.

(5) "Complete records" means written records required to be kept in Oregon as described in OAR 436-050-0110 and 0120 and OAR 436-050-0210 and 0220.

(6) "Controlling person" means a person having substantial ownership or who is an officer or director of a corporation; a member or manager of a limited liability company; a partner of a partnership; or an individual who has, directly or indirectly, the power to direct or cause the direction of the management, policies, or operation of a person offering worker leasing services.

(7) "Days" means calendar days unless otherwise specified.

(8) "Default" means failure of an employer, insurer, or self-insured employer to pay the moneys due the director under ORS 656.506, 656.612, and 656.614 at such intervals as the director directs.

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

(10) "Director" means the director of the Department of Consumer and Business Services or the director's delegate for the matter, unless the context requires otherwise.

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

(12) "Fiscal Year" means the twelve-month period beginning July 1 and ending June 30.

(13) "Governmental subdivision" means cities, counties, special districts defined in ORS 198.010, intergovernmental agencies created under ORS 225.050, school districts as defined in ORS 255.005, public housing authorities created under ORS chapter 456, or regional council of governments created under ORS chapter 190.

(14) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

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

(16) "Leased worker" means any worker provided by a worker leasing company on other than a "temporary basis" as described in OAR 436-050-0420.

(17) "Nonrenewal" means the insurer's decision not to renew a policy at its expiration date.

(18) "Person" means an individual, partnership, corporation, joint venture, limited liability company, association, government agency, sole proprietorship, or other business entity allowed to do business in the state of Oregon.

(19) "Premium" means the monetary consideration for an insurance policy.

(20) "Premium assessments" means moneys due the director under ORS 656.612 and 656.614.

(21) "Process claims" is the determination of compensability and management of compensation by an Oregon certified claims examiner. Determining compensability and managing compensation must be done from within this state under ORS 731.475 and this definition. Insurers and self-insured

employers may receive claims reports at locations out-of-state as long as claims are forwarded to an Oregon location for processing. The act of making payment may be done from out-of-state as directed from the Oregon place of business.

(22) "Proof of coverage" for purposes of OAR 436-050 has the same meaning as defined in OAR 436-162-0005.

(23) "Renewal" or "renew" means the issuance of a policy succeeding a policy previously issued and delivered by the same insurer or the issuance of a certificate or notice extending the terms of an existing policy for a specified period beyond its expiration date.

(24) "Reinstatement" means the continuation or reestablishing of workers' compensation insurance coverage, as noted by the effective date of the reinstatement, under a workers' compensation insurance policy that was previously canceled.

(25) "Self-insured employer" means an employer who has been certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407.

(26) "Self-insured employer group" means five (5) or more employers certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407 and OAR 436-050-0260 through 436-050-0340.

(27) "State" means the State of Oregon.

(28) "Substantial ownership" means a percentage of ownership equal to or greater than the average percentage of ownership of all the owners, or ten percent, whichever is less.

(29) "Worker leasing company" means a "person," as described in section (18) of this rule, who provides workers, by contract and for a fee, as established in ORS 656.850.

(30) "Written" means that which is expressed in writing, and includes electronic records.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.704 and 656.726(4)
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0006 Administration of Rules

Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and these rules are considered orders of the director.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.704 and 656.726(4)
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0008 Administrative Review and Contested Cases

(l) Any party as defined by ORS 656.005, including an assigned claims agent under ORS 656.054, aggrieved by an action taken under these rules in which a worker's right to compensation or the amount thereof is directly in issue may request a hearing by the Hearings Division of the Workers' Compensation Board under ORS chapter 656 and the board's Rules of Practice and Procedure for Contested Cases under the workers' compensation law except where otherwise provided in ORS chapter 656.

(2) Any party as described in section (1) aggrieved by a proposed order or proposed assessment of civil penalty of the director or division issued under ORS 656.254, 656.735, 656.745, or 656.750 may request a hearing by sending a written request to the Workers' Compensation Division's administrator within 60 days after the order was mailed.

(3) A hearing will not be granted if the request:

(a) Fails to state the specific grounds for which the party contests the proposed order or assessment; or

(b) Is mailed or delivered to the administrator more than 60 days after the order was mailed.

(4) Under ORS 656.704(2) and 731.240(1), any party that disagrees with an action or order of the director or division under these rules, other than as described in section (2), may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

(5) Any party described in section (1) aggrieved by an action taken under these rules by another person except as described in sections (1) through (3) above may request administrative review by submitting a written request to the administrator. The request must specify the grounds upon which the action is contested and be received by the administrator within 90 days of the contested action unless the administrator determines there was good cause for delay or that substantial injustice may otherwise result.

Stat. Auth: ORS 656.704, 656.726(4), and 656.745
Stats. Implemented: ORS 656.254, 656.735, 656.740, 656.745, and 656.750
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0015 Suspension and Revocation of Authorization to Issue Workers' Compensation Insurance Policies

(1) Under ORS 656.447, the director may suspend or revoke the insurer's authority to renew or issue workers' compensation insurance policies upon a determination that the insurer has failed to comply with its obligations under the policy or that it has failed to comply with the law, rules, or orders of the director.

(2) For the purpose of this rule:

(a) "Suspend" or "suspension" means a stopping by the director of the insurer's authority to issue new workers' compensation insurance policies for a specified period of time.

(b) "Revoke" or "revocation" means a permanent revocation by the director of an insurer's authority to renew or issue workers' compensation insurance policies.

(c) "Show-cause hearing" means an informal meeting with the director or designee in which the insurer will be provided an opportunity to be heard and present evidence regarding any proposed orders by the director to suspend or revoke an insurer's authority to issue workers' compensation insurance policies.

(3) Suspension or revocation under this rule will not be made until the insurer has been given notice and the opportunity to be heard through a show-cause hearing before the director and show cause why it should be permitted to continue to issue workers' compensation insurance policies.

(4) A show-cause hearing may be held at any time the director finds that an insurer has failed to comply with its obligations under a workers' compensation insurance policy or has failed to comply with law, rules, or orders of the director.

(5) Following a show-cause hearing, the director may rescind the proposed order if the insurer establishes to the director's satisfaction its ability and commitment to comply with ORS Chapter 656 and these rules.

(6) A suspension may be in effect for a period of up to 18 months. A suspended insurer may continue to serve existing accounts and renew any existing policy, unless the policy nonrenews or is canceled during the period of suspension.

(7) After 12 months of the suspension has elapsed, the division may audit the performance of the insurer. If the insurer is in compliance, the administrator may request the director to lift the suspension before the 18 months has elapsed. If the insurer is not in compliance, the administrator may request the director revoke the insurer's authority to issue workers' compensation insurance policies.

(8) When an insurer's authority to issue workers' compensation insurance policies has been revoked, the insurer may serve an existing account only until the policy is canceled or until the next renewal date, whichever first occurs.

(9) After a revocation of an insurer's authority to issue workers' compensation insurance policies has been in effect for five years or longer, it may petition the director to restore its authority by submitting a plan demonstrating its ability and commitment to comply with the workers' compensation law, these rules, and orders of the director.

(10) Appeal of proposed and final orders of suspension and revocation issued under this rule may be made as provided in OAR 436-050-0008.

(11) Any order of suspension or revocation issued under ORS 656.447 and this rule is a preliminary order subject to revision by the director.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.447
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0025 Service of the Notice of Civil Penalty Orders

When the director issues a civil penalty order, it will be served by certified mail, return receipt requested, or in any other manner provided by Oregon Rules of Civil Procedure (7)(D). Proof of service may include a hard copy signed receipt or electronic verification.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.704, 656.726, and 656.740
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0040 Responsibility for Providing Coverage When a Contract Is Awarded

(1) In the operation of ORS 656.029 a subject employer who fails to comply with ORS 656.017 is a "noncomplying employer" as defined by ORS 656.005.

(2) For the purposes of this rule:

(a) "Assistance of others" means one or more individuals directly and immediately aiding in a common undertaking.

(b) "Normal and customary part or process of the person's trade or business" refers to the day-to-day activities or operations which are necessary to successfully carry out the business or trade.

(3) Under ORS 656.037, a person contracting to pay remuneration for professional real estate activity as defined in ORS chapter 696 to a qualified real estate broker or qualified principal real estate broker, as defined in ORS 316.209, is not an employer of the qualified broker.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.029 and 656.037
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0045 Non-Subject Workers

(1) As used in ORS 656.027(1):

(a) "Private employment contract" means direct employment of the worker by the owner of the private home.

(b) As used in this rule, "owner of the private home" means any person who occupies and either owns, leases, or rents the private home, or any person related by blood, marriage, or an Oregon registered domestic partnership to that person, or any person who by direction of that person or by order of a court has become responsible for managing the household affairs of that person.

(2) As used in ORS 656.027(19):

(a) "A person performing foster parent duties" means any person certified by the Oregon Department of Human Services under ORS chapter 418 as a foster parent, or any person employed by that person in the operation of a foster home as defined in ORS chapter 418 and any rules promulgated thereunder.

(b) "A person performing adult foster care duties" means any person licensed by the Oregon Department of Human Services or Oregon Health Authority to operate an adult foster home, or any person employed by the operator to perform services of assistance to the residents of the adult foster home.

(3) As used in this rule, "adult foster home" means any family home or facility, licensed under ORS 443.705 to 443.825, in which room, board, and 24-hour care services are provided, for compensation, to five or fewer adults who are not related to the operator by blood or marriage.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.027
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0050 Corporate Officers, Partnerships; Limited Liability Company Members; Subjectivity

(1) Under ORS 656.027, a corporation, limited liability company, or partnership must elect in writing to its insurer to provide workers' compensation coverage for otherwise nonsubject workers. The election must be made at the inception of a coverage policy and remain in effect until a revised written designation is given to the insurer. A self-insured employer must file the election with the director. If an entity does not file its initial election, or is not in compliance under ORS 656.017 and 656.407, then those exempt individuals will be determined in the following order:

(a) For a corporation:

(A) President;

(B) Secretary, if any;

(C) Vice President, if any;

(D) Secretary/Treasurer, if any;

(E) Treasurer, if any;

(F) All other officers, if any.

(b) For a limited liability company or partners of a partnership:

(A) The member or partner with the largest ownership interest;

(B) The next largest ownership interest.

(c) If there is more than one person or the ownership interest is the same in any of the offices listed in subsections (a) and (b) of this rule, the sequence of those persons will be determined by whose birthday falls earlier in a year.

(2) Noncomplying corporations, noncomplying limited liability companies, or noncomplying partnerships, regardless of the number of employees, are limited to two exempt officers, members, or partners to be determined in accordance with section (1) of this rule.

(3) For purposes of clarifying terms used in ORS 656.027:

(a) "Commercial harvest of timber" means all commercial activities relating to harvest of timber from a parcel of property including, but not limited to, road building, marking of trees to be cut, timber falling, slash removal, and transportation of timber to the location where it will be processed into lumber or other products.

(b) "Director" means a person elected or appointed to a corporation's board of directors in accordance with its articles of incorporation or bylaws.

(c) "Eligible officer" means a corporate officer who is also a director of the corporation and who has a substantial ownership interest in the corporation.

(d) "Eligible partner" or "eligible member" means a partner or member who has substantial ownership in the business entity.

(e) "Noncomplying" means an employing legal entity of subject workers which is in violation of ORS 656.017(1).

Stat. Auth: ORS 656.704 and ORS 656.726(3)
Stats. Implemented: ORS 656.027
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0055 Extraterritorial Coverage

(1) Criteria to be used in determining whether a worker is temporarily in or out of state under ORS 656.126 may include, but are not limited to:

(a) The extent to which the worker's work within the state is of a temporary duration;

(b) The intent of the employer in regard to the worker's employment status;

(c) The understanding of the worker in regard to the employment status with the employer;

(d) The permanent location of the employer and its permanent facilities;

(e) The circumstances and directives surrounding the worker's work assignment;

(f) The state laws and regulations to which the employer is otherwise subject;

(g) The residence of the worker;

(h) The extent to which the employer's work in the state is of a temporary duration, established by a beginning date and expected ending date of the employer's work; and

(i) Other information relevant to the determination.

(2) Within 30 days after coverage of an Oregon employer is effective, the insurer providing the coverage must notify the employer in writing of the provisions of ORS 656.126 and this rule.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.126
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0060 Transition from Guaranty Contract Filings to Policy-Based Proof of Coverages

(1) Proof of coverage reporting requirements are prescribed by OAR 436-162.

(2) An active guaranty contract on file with the director on or after July 1, 2009 meets the Oregon proof of coverage requirement until it is replaced by a proof of coverage filing for renewal or new coverage effective on or after July 1, 2009, or until canceled under ORS 656.423 or 656.427. Active guaranty contracts on file with the director will not serve as proof of coverage on or after July 1, 2010.

(3) Filings for policies with a coverage effective date before July 1, 2009 create, endorse, cancel, or reinstate a guaranty contract. Filings for policies with a coverage effective date on or after July 1, 2009 establish, endorse, cancel, or reinstate proof of coverage filings.

(4) A guaranty contract in effect on or after July 1, 2009 is canceled the earliest of:

(a) The employer obtaining other Oregon workers' compensation coverage and causing the insurer to make a coverage filing with the director;

(b) The employer providing the insurer 30 days written notice of cancellation; or

(c) The insurer mailing notice of cancellation to the employer at least 45 days prior to the cancellation effective date, 90 days notice if the cancellation is based on an insurer's decision not to offer insurance to employers with a specific premium category, or 10 days notice if the cancellation is based on nonpayment of premium.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.419, 656.427
Hist: Amended 9/17/08 as WCD Admin. Order 08-061, eff. 7/1/09
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0110 Notice of Insurer's Place of Business in State; Coverage Records Insurer Must Keep in Oregon

(1) Every insurer that is authorized to issue workers' compensation coverage to subject employers as required by ORS chapter 656 must give the director notice of the location, mailing address, telephone number, and any other contact information in this state where the insurer processes claims and keeps written records of claims and proof of coverage as required by ORS 731.475. The insurer may not have more than eight locations at any one time where claims are processed or records are maintained. While the insurer may have more than one location in this state, the information provided to the director must reasonably lead an inquirer to a person who can respond to inquiries as to workers' compensation insurance policy, claim filing, and claims processing location information and to access an in-state Oregon certified claims examiner who can respond within a reasonable time to specific claims processing inquiries. A response time of 48 hours or less, not including weekends or legal holidays, would satisfy a reasonable expectation.

(2) Notice under section (1) of this rule must be filed with the director within 30 days after the insurer becomes authorized and starts writing workers' compensation insurance policies for Oregon subject employers, and must also include contact information for:

(a) A designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director; and

(b) A designated person or position within the company who can respond to workers' compensation policy and proof of coverage filing inquiries.

(3) If an insurer elects to use a service company to satisfy the purposes of ORS 731.475 with respect to all or any portion of its business, the insurer must, prior to using the service company in Oregon, file with the director a copy of the agreement between the insurer and each company for approval, and must give the director notice of the location and mailing address of each service company. The service agreement must:

(a) Be between the underwriting insurer and a service company that is incorporated in or authorized to do business in Oregon, and must not be between any other third parties;

(b) Identify the insurer by company name, or if multiple insurers related by ownership, by the name of the group if it includes all affiliates;

(c) Identify the service company by name;

(d) Grant the service company a power of attorney to act for the insurer in workers' compensation claims proceedings under ORS chapter 656; and,

(e) Contain only those provisions for workers' compensation activities that are allowed in Oregon.

(4) If the insurer's or its service company's place of business or contact information will change, the insurer must notify the director of the new location, mailing address, telephone number, and any other contact information at least 30 days before the effective date of the change.

(5) When an insurer changes claims processing locations, service companies, or self-administration, the insurer must provide at least 10 days prior notice to workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, and mailing address of the new claim processor. The insurer must also provide at least 10 days prior notice to the director of which claims will be transferred. The notice to the director must include:

(a) Contact information for both the sending processor and receiving processor of the claims to include a contact person, telephone number, mailing address, and physical address where the claims are to be processed;

(b) Verification of whether the claims to be transferred include closed claims; and

(c) A listing of the claims being transferred that identifies the underwriting insurer, employer, claimant name, date of injury, and sending processor's claim number.

(6) For the purpose of this rule, those activities conducted at designated in-state location(s) and by the authorized representative(s) of the insurer must include, but need not be limited to:

(a) Processing and keeping complete records of claims for compensation;

(b) Responding to specific claims processing inquiries;

(c) Keeping records of payments of compensation;

(d) Keeping records, including records of claims processed by prior service companies, in a written form, not necessarily original form, and making those records available upon request; and

(e) Accommodating periodic in-state audits by the director.

(7) Records every insurer is required to keep in this state include all the written records of the insurer that show its insured employers have complied with ORS 656.017, including the records described by OAR 436-050-0120.

Stat. Auth: ORS 731.475, 656.704, and 656.726(4)
Stats. Implemented: ORS 731.475
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0120 Records Insurers Must Keep in Oregon; Removal and Disposition

(1) The records of claims for compensation that each insurer is required to keep in this state include:

(a) Written records used and relied upon in processing claims;

(b) A written record of all payments made as a result of any claim including documentation of the date the payment was mailed. Documentation may be the actual mailing date, or an explanation of the time period between the date of issuance and mailing; and

(c) A written record as to whether supplemental temporary disability benefits, as required under ORS 656.210(5) for workers employed in more than one job, were approved or denied.

(2) Records of a denied claim may be removed from this state after all the appellate procedures have been exhausted and the denial has been affirmed by operation of law.

(3) Records of any claim for a compensable injury may be removed from this state after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur.

(4) When a denied claim is found to be compensable, the records of the claim are subject to section (3) of this rule.

(5) The insurer may destroy claims records when the insurer can verify that all potential for benefits to the worker or the worker's beneficiaries is gone.

(6) The records relating to proof of coverage that insurers are required to keep in the state include:

(a) A written record of each workers' compensation insurance policy and related endorsements, reinstatements, or cancellations issued as required under the workers' compensation law;

(b) Written records of premiums due and premiums collected by the insurer from its insured employers as a result of coverage issued under the workers' compensation law; and

(c) Written records that segregate and show specifically for each employer the amounts due from the employer and all such money collected and paid by the insurer for premiums for insurance coverage, premium assessments, and any other moneys due the director or required to be remitted to the director.

(7) If all remittances have been made, proof of coverage records may be disposed of after the next Insurance Division examination under ORS 731.300 or the end of three full calendar years following the calendar year in which the workers' compensation insurance policy cancels or is not renewed, whichever occurs later.

Stat. Auth: ORS 731.475, 656.704, and 656.726(4)
Stats. Implemented: ORS 731.475
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0150 Qualifications of a Self-Insured Employer

(1) To qualify as a self-insured employer, the employer must:

(a) Establish proof that the employer has an adequate staff qualified to process claims;

(b) Establish proof of the financial ability to make certain the prompt payment of all compensation and other payments due under ORS chapter 656;

(c) Obtain excess insurance coverage in the amounts approved by the director; and

(d) Be registered and authorized to do business in this state under ORS chapters 58, 60, 62, 63, 65, 67, 70, and 648, as applicable.

(2) An employer establishes proof of an adequate staff qualified to process claims by:

(a) Employing and retaining at each claims processing location, at least one person that is qualified in accordance with OAR 436-055-0070 and is actually involved in the claims processing function; or

(b) Contracting the services of one or more service companies that employ at each claims processing location in this state, at least one person qualified in accordance with OAR 436-055-0070 and that is actually involved in the self-insured employer's claims processing.

(3) An employer establishes proof of financial ability by providing a security deposit that the director determines is acceptable in accordance with OAR 436-050-0165, and in an amount as determined in accordance with OAR 436-050-0180.

(4) Failure of a certified self-insured employer to maintain the qualifications required in this rule will result in revocation of the employer's self-insured certification. The employer will be given 30 days written notice of the intent to revoke the self-insured certification, to be effective 30 days from the date of receipt of the revocation notice. If the employer complies with the qualification requirements within the 30-day period, the revocation will be canceled and the certification will remain in effect.

Stat. Auth: ORS 656.407, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.407
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0160 Applying for Certification as a Self-Insured Employer

(1) An employer applying for certification as a self-insured employer must submit:

(a) A completed "Application for Self-Insurance" (Form 440-1868);

(b) Proof of the employer's claims processing ability by employing and retaining at each claims processing location, at least one person that is actually involved in the claims processing function and is qualified in accordance with OAR 436-055-0070; or by contracting with a service company that will have at least one person qualified in accordance with OAR

436-055-0070, that will be processing the employer's claims in this state, under ORS 656.455(1);

(c) The employer's audited financial statements or audited annual reports for the last three fiscal or calendar years. If the audited financial statements of a parent company are provided in lieu of statements for the employer, the director will not authorize the individual employer to be self-insured under its own program, unless a parental company guarantee can be obtained. Otherwise, it will be necessary for the parent company to be the self-insured employer or to separately insure the employer. In the context of this section, a parent company is a legal entity that owns a majority interest in the employer, or owns a majority interest in another entity or succession of entities that own a majority interest in the employer;

(d) The employer's most recent experience rating modification worksheet and supporting documentation. Applicants with prior Oregon experience who do not submit this data will be assigned a 1.50 experience rating modification pending receipt of the data. All those without prior Oregon experience will be assigned a 1.00 experience rating modification;

(e) The type, retention, and limitation levels of excess workers' compensation insurance the employer is planning to obtain as required by OAR 436-050-0170;

(f) If applicable, within 30 days after the date of certification, a service agreement between the employer and service company that has been signed by both parties. The agreement must also contain the location, mailing address, telephone number, and any other contact information of the service company;

(g) Evidence from a surety bond company admitted to do surety business in this state that they will issue a surety bond for the employer, as Principal, and the Oregon Department of Consumer and Business Services, Workers' Compensation Division, as Obligee; or evidence from a qualified bank that they will issue an irrevocable standby letter of credit for the employer with the Oregon Department of Consumer and Business Services as the beneficiary;

(h) Evidence of an occupational safety and health loss control program in accordance with OAR 437-001 as required by ORS 656.430(10); and

(i) Evidence of authorization to do business in this state under ORS chapters 58, 60, 62, 63, 65, 67, 70, and 648, as applicable.

(2) Within 30 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the employer that the request for certification as a self-insured employer is denied and the reason therefore; or, that the employer is qualified as a self-insured employer. If the employer qualifies as a self-insured employer, the notice will include:

(a) The type and the amount of the security deposit required;

(b) Approval of the type, retention, and limitation levels of the excess insurance; or

(c) The type, retention, and limitation levels of excess insurance required.

(3) If approved, the certification of self-insurance will be issued upon receipt of the security deposit and the appropriate excess insurance binder.

(4) Unless a later date is specified by the applicant, the effective date of certification will be the first day of the month following the date the requirements of section (3) of this rule are met.

(5) Notwithstanding subsection (l)(c) of this rule, an employer making application may submit certified financial statements in lieu of audited financial statements or annual reports. However, the director may require the employer to submit audited financial statements if the certified financial statements submitted are insufficient to evaluate the employer's financial status.

Stat. Auth: ORS 656.430, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.430
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0165 Security Deposit Requirements

(1) For the purposes of this rule:

(a) "Employer" includes employer groups;

(b) "Self-insured employer" includes self-insured employer groups; and

(c) "ISLOC" means irrevocable standby letter of credit.

(2) A self-insured employer is required to provide a security deposit that is acceptable to the director, to establish proof of its financial ability, and to be qualified and certified as a self-insured employer or to be certified as a self-insured employer group. In accordance with ORS 656.407, a surety bond or an irrevocable standby letter of credit (ISLOC) may be accepted for the required security deposit if it complies with the following conditions and requirements:

(a) An ISLOC may be approved by the director as all or part of the security deposit. The director may approve the ISLOC if the issuing bank and the ISLOC meet the requirements of this rule:

(A) The ISLOC must be issued by or confirmed by an Oregon state chartered bank or a federally chartered bank from which funds will be immediately payable on demand. The bank issuing the ISLOC must, at the time of issuance, have a credit rating as set forth below:

(i) An "Aaa", "Aa", or "A" long term certificate of deposit (CD) rating in the current monthly edition of "Moody's Statistical Handbook" prepared by Moody's Investors Service Inc., New York; or

(ii) An "AAA", "AA" or "A" long term certificate of deposit (CD) rating in the current quarterly edition or monthly supplement of "Financial Institutions Ratings" prepared by Standard & Poors Corporation, New York.

(B) Federally chartered instrumentalities of the United States operating under authority of the Farm Credit Act of 1971 as amended, are acceptable without rating.

(C) An ISLOC issued by a bank that does not meet the credit rating set forth in paragraph (A) at the time of issuance will only be accepted with a confirming ISLOC issued by an Oregon state chartered bank or federally chartered bank meeting the credit criteria of paragraph (A). The confirming ISLOC must state that the confirming bank is primarily obligated to pay on demand the full amount of the ISLOC regardless of reimbursement from the bank whose ISLOC is being confirmed.

(D) The issuing bank must use the Irrevocable Standby Letter of Credit, Form 440-3640, issued by the director.

(E) The ISLOC will be automatically extended without amendment for an additional one (1) year from the expiry date, or any subsequent expiry date, unless, at least 60 days before the expiry date, the director is notified in writing by registered mail or overnight delivery, that the bank has elected not to extend the ISLOC for another period.

(F) If the issuing bank or any confirming bank is closed at the time of expiry of the ISLOC for any reason that would prevent delivery of a demand notice during its normal hours of operation, the ISLOC will be automatically extended for a period of 30 days commencing on the next day of operation.

(G) The ISLOC can be called immediately if:

(i) The self-insured employer has defaulted in payment of its workers' compensation liabilities or obligations, or in payments due to the director under ORS chapter 656;

(ii) The self-insured employer has filed for bankruptcy;

(iii) The self-insured employer has failed to renew or provide acceptable substitute security by fifteen (15) days prior to the expiry date of the ISLOC; or

(iv) The beneficiary has determined the existing security is deemed inadequate, that additional or replacement security must be provided by the self-insured employer, and that neither has been provided, notwithstanding written notice to the self-insured employer.

(H) The credit must be available by presentation of the beneficiary's draft drawn at sight on the issuing bank, payable within three business days, when accompanied by one of the statements contained in 436-050-0165(2)(a)(G) signed by the director of the Department of Consumer and Business Services, or the administrator of the Workers' Compensation Division, or their designated authorized representative.

(I) The ISLOC is not subject to any qualifications or conditions by the issuing bank or confirming bank and is each bank's individual obligation, which is in no way contingent upon reimbursement.

(J) An ISLOC must include a statement that the funds provided by the ISLOC are not construed to be an asset of the self-insured employer and a statement that if legal proceedings are initiated by any party with respect to the payment of any ISLOC, it is agreed that such proceedings must be subject to the jurisdiction of Oregon courts and Oregon law.

(K) Payment of any amount under an ISLOC must be made only by wire transfer in the name of the "Department of Consumer and Business Services In Trust For [the legal name of the certified self-insured employer]" to a department account, with the State Treasurer, at a designated bank.

(L) An ISLOC is subject to the International Standby Practices 1998 (ISP98), ICC Publication No. 590, which is hereby incorporated by reference, and a reference to this publication must be included in the text of the ISLOC. ICC Publication 590 may be obtained from the International Chamber of Commerce website: **http://iccwbo.org/policy/banking/**.

(M) All bank charges for the ISLOC are for the account of the applicant.

(N) Any amendment to the ISLOC must be approved and accepted by the director before the amendment is effective.

(O) If a bank's rating subsequent to the issuance of the ISLOC falls below the acceptable rating level as set forth in paragraph (A), the self-insured employer must, within 60 days of the publication of the lower credit rating:

(i) Replace the ISLOC with a new ISLOC issued by an Oregon state chartered bank or with a federally chartered bank with an acceptable credit rating;

(ii) Confirm the ISLOC by an Oregon state chartered bank or a federally chartered bank that has an acceptable credit rating; or

(iii) Replace the ISLOC with a policy of insurance or a surety bond of equal amount that is approved by the director, as substitute security for the ISLOC, if the policy of insurance or surety bond covers all workers' compensation liabilities and obligations that would have been covered by the ISLOC.

(P) Each self-insured employer that submits an acceptable ISLOC as its security deposit, must furnish a memorandum of understanding with the ISLOC, on the department's Form 440-3529, that affirms the self-insured employer's acceptance of all of the following requirements:

(i) An ISLOC is furnished to the director instead of a surety bond or other forms of security that may be determined to be acceptable for certification as a self-insured employer or for continuing as a certified self-insured employer;

(ii) The self-insured employer understands the ISLOC will be automatically extended without amendment for an additional one (1) year from the expiry date, or any subsequent expiry date, unless, at least 60 days before the expiry date, the director is notified in writing by the bank that the ISLOC will not be renewed;

(iii) The ISLOC may be replaced with an ISLOC or surety bond of equal amount or a policy of insurance that is accepted by the director as substitute security for the ISLOC, if the new ISLOC or surety bond or policy of insurance covers all workers' compensation liabilities and obligations that would have been covered by the ISLOC to be replaced;

(iv) The self-insured employer affirms that the ISLOC, in the amount required, is being offered with the understanding that the ISLOC can be called immediately, at the director's discretion, if the director receives notice that the ISLOC will not be renewed; if the self-insured employer fails to pay its workers' compensation liabilities, obligations, or payments due to the director under ORS chapter 656; or the self-insured employer files bankruptcy; or the self-insured employer fails to renew or provide acceptable substitute security by fifteen (15) days prior to the expiry date of the ISLOC; or the director has determined the existing security is deemed inadequate, that additional or replacement security must be provided by the self-insured employer and that neither has been provided, notwithstanding written notice to the self-insured employer; and

(v) If legal proceedings are initiated by any party with respect to payment of any ISLOC, then it is agreed that the proceedings will be subject to the jurisdiction of Oregon courts and application of Oregon law.

(b) A surety bond may be accepted by the director as a security deposit or substitute security deposit for an ISLOC, government securities, monies, or time deposits. A surety bond may be accepted as all or part of the security deposit. The director, in each particular case, will determine if the surety bond submitted is acceptable, if the issuing surety is acceptable, and if its language and format are acceptable.

(A) The surety bond must be issued by a surety company authorized to transact surety business in Oregon;

(B) Surety Bond Form 440-824 must be used for all surety bonds;

(C) Surety bonds submitted for the self-insured employer's security deposit must be continuous in form;

(D) Surety bonds may be terminated by the surety company by giving the director and the Principal written notice stating that on a date not less than thirty days after the date the notice is received by the director, such termination will be effective. Such termination in no way limits the liability of the Surety for subsequent defaults of the Principal's liability or obligations incurred under ORS chapter 656 prior to the effective date of such termination;

(E) Surety Bond Rider Form 440-1810 must be used for all department required increases or authorized decreases in the penal sum of the surety bond. The surety bond rider is not effective until it is accepted by the department;

(F) Surety bonds and all riders to the surety bonds must be executed by the surety company's attorney in fact and the attorney in fact's appointment and power of attorney must accompany all surety bonds and riders submitted. The power of attorney must authorize the attorney in fact to execute the surety bond in the amount of the penal sum of the bond;

(G) The liability of a surety company under its surety bond may only be discharged in the event that:

(i) The Principal files acceptable substitute security as the security deposit that is accepted by the director as substitute security for the surety bond to be released, covering all past, present, existing, and potential liability of the Principal under ORS chapter 656 and covering all the Surety's liability under the surety bond to be released, in an amount required by the director; and

(ii) The surety bond is released as documented in writing from the director or the administrator of the Workers' Compensation Division, or their designated authorized representative.

(iii) A policy of insurance or an ISLOC of equal amount that is acceptable by the director may be accepted as substitute security for the surety bond if the policy of insurance or ISLOC covers all workers' compensation liabilities and obligations that would have been covered by the surety bond.

(H) The surety company or its parent must have and maintain an acceptable credit rating in accordance with the following:

(i) Standard and Poors Insurer Financial Strength Rating of A or better rating, or

(ii) A.M. Best Company, Financial Strength Rating of B+ or better rating.

(I) A surety bond must be replaced by the self-insured employer with an acceptable type of security deposit within 30 days after notice from the department that the Surety has been placed in conservatorship, is seized, or declares insolvency, or the current credit rating is below the ratings required in subsection (H).

(c) Government securities, certificates of deposit, or time deposit accounts that were accepted by the director as a self-insured employer's or a self-insured employer group's required security deposit prior to January 1, 2004, may remain as the security deposit until the maturity date of those investments. At that time, the government securities, certificates of deposit, or time deposit accounts pledged to the department as security deposits must be replaced by a surety bond or ISLOC acceptable to the director. A self-insured employer that has government securities, certificates of deposit, or time deposit accounts as all or part of its security deposit must complete a "Security Agreement and Notice to Intermediary," Form 440-4023, granting the department a security interest in and control over those financial assets.

(d) Government securities, certificates of deposit, or time deposit accounts will not be accepted as security deposits for certified self-insured employers who must increase their security deposit or for employers whose self-insurance certification was granted after January 1, 2004.

Stat. Auth: ORS 656.430, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.430
Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0170 Excess Insurance Requirements

(1) A self-insured employer must have excess workers' compensation insurance coverage appropriate for the employer's potential liability under ORS 656.001 to 656.990 with an insurer authorized to do business in this state. Except

for endorsements requiring pre-approval by the director in sections (4) and (5), the policy providing such coverage and any endorsements thereto must be filed with the director not later than 30 days after the date the coverage is effective. A self-insured public utility with assets in excess of $500 million as reflected by the employer's audited financial statement submitted in accordance with OAR 436-050-0160 or 436-050-0175, may obtain the required excess workers' compensation insurance coverage from an eligible surplus lines insurer.

(2) The excess insurance:

(a) Must include a provision for reimbursement to the director of all expenses paid by the director on behalf of the employer under ORS 656.614 and 656.443 in the same manner as if the director were the insured employer, subject to the policy limitations or amounts and limits of liability to the insured employer; and

(b) Coverage must be continuous and remain in effect from the date of certification until the certification is revoked or canceled; and

(c) Coverage must be specific on a per occurrence basis; and

(d) Coverage may include aggregate excess insurance; and

(e) Coverage may include a deductible endorsement acceptable to the director under sections (4) and (5) of this rule.

(3) The self-insured retention level for a self-insured employer group's excess insurance policy must not be less than $300,000.

(4) Changes in the self-insured retention level and policy limits of the excess insurance require prior approval of the director. The director may require a reduction in the self-insured retention level or an increase in the policy limits. Those items considered in determining and approving the retention and limitation levels of the excess insurance will be the employer's:

(a) Financial status;

(b) For self-insured employer groups, financial viability as determined under OAR 436-050-0260;

(c) Risk and exposure;

(d) Claim history; and

(e) The amount of the required security deposit.

(5) Endorsements addressing a per-accident deductible in excess of a self-insured employer group's retention level require prior approval of the director. In determining whether to approve a deductible endorsement, the director will consider the group's retention level, policy limits, and the items in section (4) of this rule. The director will not approve per-accident deductible endorsements in excess of the retention level that contain language allowing the excess insurer, at its discretion, to limit its obligations under section (2)(a) of this rule.

(6) A self-insured employer will be allowed a period, not to exceed 30 days, within which to comply with an order of the director to the employer to reduce the self-insured retention level or increase the policy limitation or amounts and limits of liability of the excess insurance.

(7) Excess insurance obtained under this section does not relieve any self-insured employer from full responsibility for claims processing and the payment of compensation required under ORS chapter 656 and these rules. Regardless of the types and amounts of excess coverage a self-insured employer must not transfer claims to the excess insurer(s) for processing.

(8) When an excess insurance policy is canceled by the excess insurer or the employer, a copy of such notice must be filed with the director 30 days before the effective date of cancellation.

(9) If a self-insured employer does not comply with the requirements of this section, the employer's certification as a self-insured will be revoked. The employer will be given written notice of such revocation which will be effective 30 days from receipt of the notice. If the required excess insurance is obtained within the 30 days, the revocation will be canceled and certification will remain in effect.

Stat. Auth: ORS 656.430, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.430
Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0175 Annual Reporting Requirements

(1) To determine the financial status of a self-insured employer and to evaluate the employer's continuity of operation, a self-insured employer must file annually with the director an audited financial statement or annual report with audited financial statement, including SEC Form 10K if issued, for the just completed fiscal year. A self-insured employer that is not a municipality must make the filing within 120 days of the fiscal year end and a self-insured employer that is a municipality must make the filing within 180 days of the fiscal year end. All financial statements and annual financial reports filed, as required by this section, will be retained by the director for a period of at least three years. In lieu of an audited financial statement or annual report, a self-insured employer may file a financial statement certified by the employer that the financial statement is true and accurate and presents the employer's financial condition and results of operations as of the date of the statement.

(2) Notwithstanding section (l) of this rule, the director may require an employer to submit an audited financial statement if the certified financial statement submitted is insufficient to evaluate the employer's financial status.

(3) The financial statements and reports filed by a self-insured employer group must demonstrate the group's acceptable financial viability based on criteria under OAR 436-050-0260 including, but not limited to, satisfactory financial ratios and net worth.

(4) By March 1 of each year, self-insured employer groups must file with the director:

(a) A statement certifying the amount of the group's combined net worth under OAR 436-050-0260(3)(a), as of the date of the statement; and

(b) A copy of the fidelity bond furnished to the group by the administrator or a copy of the comprehensive crime policy obtained by the group, in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities. If the fidelity bond or policy covers more than one year, is still in effect, and a copy was provided to the director in the prior year, the group's annual filing may state that fact in lieu of providing an additional copy.

(5) By March 1 of each year, self-insured employer groups consisting of private employer members must file with the director:

(a) A statement certifying that each employer member of the group meets the individual net worth requirement under OAR 436-050-0260(3)(b), as of the employer member's most recent fiscal year end; and

(b) A list of the group's current board members and their professional affiliations.

(6) The self-insured employer must report claim loss data described in Bulletin 209 by March 1 of each year for the purposes of experience rating modification, retrospective rating calculations, and determining deposits.

(a) The report must be certified to be true and accurate by an authorized representative of the self-insured employer, and must include:

(A) A report of losses for each year in the experience rating period. The report must cover all claims incurred during the reporting period and must be valued as of January 1 of the current year. Reports must include:

(i) Contract medical expenses;

(ii) Total maximum medical reimbursement amount;

(iii) Number of claims for which the maximum medical reimbursement amount is claimed;

(iv) For claims with incurred losses at or below the National Council on Compensation Insurance (NCCI) split point published in Bulletin 209, total paid, outstanding reserves, and total incurred losses;

(v) Number of claims with incurred losses at or below the NCCI split point; and

(vi) For each claim with incurred losses exceeding the NCCI split point, worker's name, date of injury, claim number, total paid, outstanding reserves, and total incurred losses. Claims must be listed in alphabetical order.

(B) A report of losses covering the self-insured period prior to the experience rating period. The report must list all open claims and must be valued as of January 1 of the current year. The report must include:

(i) The worker's name, listed in alphabetical order;

(ii) Date of injury;

(iii) Claim number;

(iv) Total paid;

(v) Outstanding reserves; and

(vi) Total incurred losses.

(C) Identification of claims involving catastrophes, Workers with Disabilities Program, permanent total disability or fatal benefits, third party recoveries, and claims where the total incurred has or is expected to exceed the self-insured retention of the self-insured employer's excess insurance policy.

(D) The total annual paid losses for the previous four fiscal years valued as of January 1 of the current year.

(b) Bulletin 209 provides guidelines for self-insured employers and their authorized representatives to use in submitting the required data. Bulletin 209 is available on the Workers' Compensation Division's website.

(c) Each self-insured city, county, or qualified self-insured employer group that is exempted from the security deposit requirements under ORS 656.407(3) and OAR 436-050-0185 must, in addition to the above, provide the director by March 1 of each year, the procedures, methods, and criteria used in the process of determining the amount of their actuarially sound workers' compensation loss fund, including procedures for determining the amount for injuries incurred but not reported. The director may require a qualified self-insured employer group exempted from the security deposit requirements to provide an actuarial study that demonstrates its loss reserve account is actuarially sound and adequately funded under OAR 436-050-0185(2)(d).

(7) Notwithstanding sections (1) through (5) of this rule, the director may require a self-insured employer group to submit financial statements, reports, or information more frequently for reasons including, but not limited to, changes in the group's financial status or viability, private employer members' individual net worth, group membership, private employer groups' board membership, or incurred claims costs.

(8) Notwithstanding section (6) of this rule, the director may require a self-insured employer to submit claim loss data more frequently if the nature of the self-insured employer's business has changed since the last annual loss report for reasons including, but not limited to, mergers or acquisitions, changes in employment level, nature of employment, or incurred claims costs.

(9) If a self-insured employer fails to comply with the requirements of sections (1) through (8) of this rule, the director may impose any or all of the following sanctions:

(a) Require the self-insured employer to increase its deposit and premium assessments by 25%;

(b) Conduct an audit to obtain the necessary loss information at the self-insured employer's expense;

(c) Assess civil penalties of up to $250 per day that the information is not provided beyond the deadline; or

(d) Revoke the employer's certification for self-insurance.

(10) To ensure each self-insured employer's claims are valued appropriately for use in deposit, experience rating, and retrospective rating calculations, the director will perform routine test audits. If a self-insured employer's total claims values are found to be 10 percent or more below the director's determined values, the current experience rating will be

recalculated using the director's determined values and will be used in the security deposit and retrospective rating calculations. In addition, penalties may be assessed.

Stat. Auth: ORS 656.407, 656.430, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.407 and 656.430
Hist: Amended 12/24/15 as WCD Admin. Order 15-067, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0180 Determination of Amount of Self-Insured Employer's Deposit; Effective Date of Order to Increase Deposit

(1) The deposit a self-insured employer is required by ORS 656.407 to maintain with the director must be an amount not less than the greater of:

(a) $100,000; or

(b) Future claim liability, including losses incurred but not reported (IBNR), a claims processing administrative cost, and the anticipated assessments payable to the director for the employer's next fiscal year; or

(c) The annual incurred losses for the self-insured's last fiscal year, including IBNR, a claims processing administrative cost, and anticipated assessments payable to the director for the employer's next fiscal year.

(2) Notwithstanding section (1) of this rule, if the employer is applying for self-insurance, the amount of the deposit must not be less than the greater of:

(a) The anticipated assessments payable to the director for the employer's next fiscal year, plus an amount equal to 65 percent of the annual premium the employer would pay if carrier-insured using the applicable occupational base rate premium, as such rate is applied to the anticipated payroll of the employer's Oregon operations for the employer's next fiscal year; or

(b) $300,000 plus $30,000 additional for each $100,000 the employer's net worth is below $2 million; or

(c) The amount of the approved self-insured retention level for the employer's excess workers' compensation insurance.

(3) In determining the amount of deposit the director will take into consideration:

(a) The financial ability of the employer to pay compensation and other payments due;

(b) The employer's probable continuity of operation;

(c) A self-insured employer group's financial viability, as determined by the director under OAR 436-050-0260;

(d) Retention and limitation levels of the employer's excess insurance in relation to the employer's financial status;

(e) Changes in the employer's business including, but not limited to, mergers or acquisitions, changes in employment level, nature of employment, incurred claims costs, or material growth in self-insured exposure; and

(f) The balance of the Self-Insured Employer Adjustment Reserve or the Self-Insured Employer Group Adjustment Reserve.

(4) The amount of the deposit determined in sections (1) through (3) of this rule for a self-insured employer group with financial ratios equaling a "moderate" rating under OAR 436-050-0260(13)(b) will be increased by the following percentage factors:

(a) 12 total combined points = no change in calculated deposit;

(b) 11 total combined points = no change in calculated deposit;

(c) 10 total combined points = 5%;

(d) 9 total combined points = 10%;

(e) 8 total combined points = 15%; or

(f) 7 total combined points = 20%.

(5) Assessments payable to the director referred to in this section include moneys and assessments due under ORS 656.506, 656.612, and 656.614.

(6) A self-insured employer will be allowed a period, not to exceed 30 days, within which to comply with an order of the director to the employer to increase the amount of its deposit.

(7) "Claims processing administrative cost" will be determined by developing a percentage rate to be applied against the employer's unpaid losses. The rate will be based on the information contained in Schedule P, Part ID of the Annual Statement for the previous calendar year as reported to the Insurance Commissioner by SAIF Corporation and the 20 private insurers who had the highest earned premium reported for the preceding calendar year. The rate will be computed annually to be effective for the subsequent fiscal year. The rate will be 105 percent of the median of ratios determined as follows for each of these insurers:

(a) "Loss expenses unpaid" for losses incurred in the latest eight years, divided by

(b) "Losses unpaid" for losses incurred in the latest eight years.

(8) "Incurred but not reported" (IBNR) will be calculated by applying a loss development factor against the employer's annual paid losses. The loss development factor will be calculated annually by the director. An IBNR may be included in the security deposit calculation when the director identifies factors including, but not limited to, a decrease in the self-insured employer's credit rating, a negative net worth, negative cash flow, high debt-to-equity ratio, or material growth in self-insured exposure.

Stat. Auth: ORS 656.407, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.407
Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0185 Qualifications for Deposit Exemption for Self-Insured Cities, Counties, and Qualified Self-Insured Employer Groups, Application Procedures, Conditions and Requirements, Revocation and Requalification

(1) A self-insured city, county, or self-insured employer group that is a municipal or public corporation under ORS 297.405, may apply to be exempt from the security deposit

requirements of ORS 656.407(2). Under ORS 656.407(3), the requirements to qualify for exemption are as follows:

(a) The city, county, or qualified self-insured employer group must be in compliance with ORS 656.407(2) and OAR 436-050-0180 as an independently self-insured employer or self-insured employer group for the three consecutive years immediately prior to applying for the exemption; and

(b) The city, county, or qualified self-insured employer group must have in effect a workers' compensation loss reserve account that is actuarially sound and that is adequately funded as determined by the annual audit under ORS 297.405 to 297.740 to pay all compensation to injured workers and amounts due the director under ORS chapter 656. The workers' compensation loss reserve account must also be dedicated to and expended only for payment of compensation and amounts due the director by the city or county under ORS chapter 656.

(2) A written application requesting exemption from ORS 656.407(2) must be submitted to the director no later than 45 days prior to the date the exemption is desired to become effective. The application must include the following supporting documentation for review and approval:

(a) A copy of the city's, county's, or qualified self-insured employer group's most recent annual audit as filed with the Secretary of State under ORS 297.405 to 297.740 that identifies the actuarially sound funded amount in the dedicated workers' compensation loss reserve if not previously filed as required by OAR 436-050-0175(1);

(b) A copy of the city's, county's, or qualified self-insured employer group's current fiscal year's approved budget documents for internal service funds that state the budgeted amount for the funded workers' compensation loss reserve account;

(c) A resolution or ordinance passed by the city's, county's, or qualified self-insured employer group's governing body that establishes an actuarially sound and adequately funded workers' compensation loss reserve account that dedicates the workers' compensation loss reserve account to and limits expenditures to only the payment of compensation and amounts due the director under ORS chapter 656. The resolution must also include the director's first lien and priority rights to the full amount of the workers' compensation loss reserve account required to pay the present discounted value of all present and future claims under ORS chapter 656; and

(d) A statement giving the amount of the current reserves for present and future liabilities, the amount funded in the workers' compensation loss reserve account, and the procedures, methods, and criteria used in the process of determining the amount funded in their actuarially sound workers' compensation loss fund, including procedures for determining the amount for injuries incurred but not reported.

(A) The statement must include the city's, county's, or qualified self-insured employer group's certification that the loss reserve account is actuarially sound and adequately funded if an actuarial study is not available.

(B) The director may require a qualified self-insured employer group to demonstrate its loss reserve account is actuarially sound and adequately funded based on an actuarial study requested under OAR 436-050-0175(6)(c). The actuarial study must include an IBNR estimate and a copy of the study must be provided to the director.

(3) Within 45 days of receipt of all information required by section (2) of this rule, the director will review the application and supporting documentation and notify the city, county, or qualified self-insured employer group that the request for exemption under ORS 656.407(3) is approved or denied.

(a) If denied, the notice will provide the reasons for the denial, any requirements for reconsideration, and the right to administrative review as provided by OAR 436-050-0008.

(b) If approved, the notice will include:

(A) The confirmation of the effective date of exemption;

(B) Authorization for cancellation of any surety bond or ISLOC held as security under ORS 656.407(2) and OAR 436-050-0180; and

(C) Procedures for release of any government securities or time deposits held as security under ORS 656.407(2) and OAR 436-050-0180.

(4) Probable cause to believe the workers' compensation loss reserve account is not actuarially sound includes but is not limited to:

(a) The annual audited financial statement under ORS 297.405 to 297.740 not containing a statement by the auditor that the workers' compensation loss reserve account is adequately funded, or containing a disclaimer regarding the auditor's qualifications or ability to determine adequacy of the loss reserve account; or

(b) For qualified self-insured employer groups required by the director to conduct an actuarial study under OAR 436-050-0175(6)(c) and section (2)(d)(B) of this rule, the actuarial study not containing a statement by the actuary that the loss reserve account is actuarially sound, or containing a disclaimer regarding the actuary's qualifications or ability to determine the adequacy of the reserves for current or future liabilities.

(5) A city, county, or qualified self-insured employer group that has been exempted from ORS 656.407(2) and desires to terminate its self-insurance certification or elects to discontinue maintaining an actuarially sound and adequately funded workers' compensation loss reserve must:

(a) Submit a written request to the director at least 60 days prior to the desired effective date the self-insured certification is requested to be terminated or 60 days prior to the effective date that the qualifying workers' compensation loss reserve account is to be discontinued;

(b) If the self-insured certification is to be terminated, the request for termination must comply with OAR 436-050-0200. Prior to the effective date of termination the city, county, or

qualified self-insured employer group must provide a security deposit, as required by the director, in an amount determined under OAR 436-050-0180 and ORS 656.443; and

(c) If the city, county, or qualified self-insured employer group desires to remain self-insured, the city, county, or qualified self-insured employer group must requalify for self-insurance certification by depositing, prior to the date the qualifying workers' compensation loss reserve account is to be discontinued, a security deposit as required by the director under ORS 656.407(2) and OAR 436-050-0180. Under ORS 656.407(3)(e) failure to deposit the required security deposit with the director prior to the date of discontinuance of the qualifying workers' compensation loss reserve account will cause the city's, county's, or qualified self-insured employer group's self-insurance certification to be automatically revoked as of that date.

Stat. Auth: ORS 656.407, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.407
Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0190 Using Self-Insured Employers Security Deposit/Self-Insured Employers Adjustment Reserve/Self-Insured Employer Group Adjustment Reserve/Director-Ordered Assessments of Private Employer Members of Self-Insured Employer Groups

(1) In the event a self-insured employer defaults or is unable to make all payments due under ORS chapter 656, the director will, on behalf of the employer, assure continued payments in accordance with ORS 656.407, 656.443, and 656.614 and in such a manner as to ensure minimum delay in the processing of injured workers' claims.

(2) If a self-insured employer defaults and is being serviced by one or more service companies, the director will, on behalf of the employer, designate those service companies to continue processing claims in accordance with the contracts in effect. At least 90 days prior to the time the contract expires, the service company can submit a proposal to continue processing the claims. The director will consider such proposal along with other options which may include referral of the claims for processing to an assigned claims agent selected under ORS 656.054.

(3) If a self-insured employer defaults and is self-administering, the director will, on behalf of the employer, negotiate to have the employer's claims processed or may refer the claims for processing to an assigned claims agent as secured under ORS 656.054.

(4) In the event a self-insured employer reorganizes its business, assumes additional liability, acquires new operations, buys an additional business, merges with another business, files bankruptcy, emerges from bankruptcy, or otherwise changes its operation in any manner that affects its workers' compensation claims liability, the self-insured employer must notify the director of the modification of business within 30 days of the event.

(5) In the event a self-insured employer group defaults or is unable to make all payments due under ORS chapter 656, is decertified by the director under ORS 656.434, or cancels its self-insurance certification, the director will, on behalf of the employer, assure continued payments in accordance with ORS 656.407, 656.443, and 656.614 and in such a manner as to ensure minimum delay in the processing of injured workers' claims.

(6) In the event a self-insured employer group reorganizes its business, assumes additional liability, acquires new operations, buys an additional business, merges with another business, files bankruptcy, emerges from bankruptcy, or otherwise changes its operation in any manner that affects its workers' compensation claims liability, or financial viability as determined under OAR 436-050-0260, the self-insured employer group must notify the director of the modification of business within 30 days of the event. Failure to comply with this rule may result in revocation of the self-insured employer group's certification.

(7) If a self-insured employer group defaults, cancels its self-insurance certification, or is decertified by the director under ORS 656.434, the director may designate the service company responsible for continuing to process the group's claims. The director's designation may include referral of the claims for processing to an assigned claims agent selected under ORS 656.054.

(8) If a self-insured employer group consisting of private employer members defaults, cancels its self-insurance certification, or is decertified by the director under ORS 656.434, the director may order private employer members of the group to pay an assessment for the group's continuing claim liabilities, under ORS 656.430(7)(a)(D)(i). Failure of the group's members to pay director-ordered assessments under this rule will subject members to civil penalties under ORS 656.745.

Stat. Auth: ORS 656.407, 656.434, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.407, 656.443, and 656.614
Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0195 Requirements for Self-Insured Entity Changes

(1) If there is any change in the legal entity, changes in addresses, telephone numbers, and points of contact, or ownership changes, a self-insured employer must notify the director in writing within 30 days after the change occurs.

(2) A self-insured employer must submit requests to add or delete entities under its self-insured certification by submitting a completed "Endorsement to Self-Insured Group Application" (Form 440-1869) signed by an officer of the company. Each entity to be approved for inclusion in a self-insured employer's certification must enter into an agreement, signed by an officer of the entity being included in the self-insured employer's certification, making the entity jointly and severally liable for the payment of any compensation and moneys due to the director by the certified self-insured employer or any other entity included in the self-insured employer's certification.

(3) The director will determine, based on the information provided, the effect of the change on the deposit required and

whether the entities can be combined for experience rating purposes.

(4) Failure to provide notification as required by this section may result in assessment of penalties or revocation of self-insurance certification, or both.

Stat. Auth: ORS 656.407, ORS 656.430, ORS 656.704 and ORS 656.726(3)
Stats. Implemented: ORS 656.407 and ORS 656.430
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0200 Self-Insured Certification Cancellation; Revocation

(1) A certification to a self-insurer issued by the director remains in effect until:

(a) Revoked as provided by OAR 436-050-0150 through 436-050-0230, ORS 656.434, and ORS 656.440; or

(b) Canceled by the employer with the approval of the director.

(2) If a self-insured employer wishes to cancel certification as a self-insured or cancel self-insurance for any legal entity included under the self-insurance certification, the employer must make written request to the director. Such a request must be submitted at least 60 days prior to the desired date of cancellation and include:

(a) What arrangements have been made to process present and future claims for which the employer is responsible;

(b) A statement of all present and future claims liabilities for all liabilities incurred during the period of self-insurance; and

(c) Any reports and moneys due the director under ORS 656.506, 656.612, and 656.614.

(3) If the employer will continue to have subject workers after the cancellation date, the employer must provide the director, prior to the desired date of cancellation, one of the following:

(a) An insurer filed proof of coverage for a workers' compensation insurance policy under ORS 656.017 and 656.419;

(b) Evidence of a worker leasing arrangement as allowed under ORS 656.850; or

(c) An assigned risk binder that demonstrates compliance with ORS 656.052.

(4) If the self-insured employer fails to provide the director evidence of subsequent coverage under section (3) prior to the desired date of cancellation, the self-insurance certification, including reports and moneys due the director under ORS 656.506, 656.612, and 656.614, will remain in effect.

(5) If a workers' compensation insurance policy is in effect and an active self insurance certification is on file with the director for the same employer for the same time period, the self- insured employer has the responsibility of processing claims occurring during the time period as provided under the self insurance certification.

(6) The certification of a self-insured employer may be revoked if:

(a) The employer fails to comply with ORS 656.407 or 656.430 and applicable rules;

(b) The employer defaults, under ORS 656.443; or

(c) The employer commits any violation for which a civil penalty could be assessed under ORS 656.745.

(7) Except as provided in OAR 436-050-0170 (9), notice of certificate revocation will be issued in accordance with the provisions of ORS 656.440.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.434 and 656.440
Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0205 Notice of Self-Insurer's Personal Elections

When a person makes an election under ORS 656.039, 656.128, or 656.140, the self-insured must notify the director in writing of the election and of any cancellation of the election within 30 days of the effective date.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.039, 656.128 and 656.140
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0210 Notice of Self-Insurer's Place of Business in State; Records Self-Insured Must Keep in Oregon

(1) Every employer certified as a self-insured employer must give the director notice of the location, mailing address, telephone number, and any other contact information of at least one location in this state where claims will be processed and claim records kept as well as other records as required by this rule and OAR 436-050-0220. The employer must give notice of the location, mailing address, telephone number, and any other contact information upon application for certification. The employer may not have at any one time more than three locations where claims are processed or records are maintained.

(2) Notice under section (1) of this rule must include contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director.

(3) With the approval of the director, a self-insured employer may use one or more service companies as authorized by ORS 656.455 instead of establishing its own place of business in this state. To obtain approval or to change or add service locations, the employer must file with the director a copy of the agreement entered into between the employer and each company, and must give the director notice of the location, mailing address, telephone number, and any other contact information of each service company.

(4) If a self-insured employer's or its service company's place of business or contact information will change, the self insured employer must notify the director of the new location, mailing address, telephone number, and any other contact information 30 days before the effective date of the change.

(5) When a self-insured employer changes claims processing locations, service companies, or self-administration, the employer must provide at least 10 days prior notice to:

(a) Workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, and mailing address of the new claim processor;

(b) The director of which claims will be transferred. The notice must include:

(A) Contact information for both the sending processor and receiving processor of the claims to include a contact person, telephone number, mailing address, and physical address where the claims are to be processed;

(B) Verification of whether the claims to be transferred include closed claims; and

(C) A listing of the claims being transferred that identifies the sending processor's claim number, claimant name, and date of injury.

(6) For the purpose of this rule, those activities conducted at designated in-state location(s) and by the authorized representative(s) of the self-insured employer must include, but need not be limited to:

(a) Processing and keeping complete records of claims for compensation;

(b) Responding to specific claims processing inquiries;

(c) Keeping records of payments for compensation;

(d) Keeping records, including records of claims processed by prior service companies, in a written form, not necessarily original form, and making those records available upon request; and,

(e) Accommodating periodic in-state audits by the director.

(7) Written records every self-insured employer is required to keep in this state include, but are not limited to, the records described by OAR 436-050-0220.

(8) Notwithstanding section (1) of this rule, the director may approve up to two additional claims processing locations, if the self-insured employer can show:

(a) That meeting the requirements of section (1) of this rule will impose a financial or operational hardship on the employer;

(b) That such additional locations will result in improved claims processing performance of the employer; and

(c) That the auditing functions of the director can be met without unnecessary expense to the director.

(9) If, upon review of a self-insured employer's claims processing performance, the performance has not remained at the levels as described in OAR 436-060, approval for additional locations provided in section (6) will be withdrawn.

(10) Notwithstanding section (1) of this rule, a self-insured employer may, with the prior approval of the director, make compensation payments from a single location other than the designated claims processing location. Approval of such a location may be revoked if at any time:

(a) Timeliness of compensation payment falls below the minimum standards as established in OAR 436-060;

(b) Written record of compensation payments is not available; or

(c) There is not sufficient written documentation to support the issuance of a check for compensation.

(11) Notwithstanding section (1) of this rule, a self-insured employer may, with prior approval of the director, have one additional location, in or out of state, for maintaining payroll records pertaining to premium assessments and assessment/contributions.

Stat. Auth: ORS 656.455, 656.704 and 656.726(4)
Stats. Implemented: ORS 656.455
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0220 Records Self-Insured Employer Must Keep in Oregon; Period to be Retained, Removal and Disposition

(1) The written records self-insured employers are required to keep in this state to ensure compliance with ORS 656.506, 656.612, 656.614, and 656.622 include:

(a) A record of payroll by National Council on Compensation Insurance classification; and

(b) Complete records of all assessments, employer and employee contributions, and all such money due the director.

(2) The self-insured employer must maintain at a place of business in this state~~,~~ those written records relating to its safety and health program as required by ORS 656.430(10) and OAR 437-001.

(3) The records of claims for compensation that each self-insured employer is required to keep in this state include, but are not limited to:

(a) Written records used and relied upon in processing claims;

(b) A written record of all payments made as a result of any claim including documentation of the date the payment was mailed. Documentation may be the actual mailing date or an explanation of the time period between the date of issuance and mailing;

(c) A written record as to whether supplemental temporary disability benefits, as required under ORS 656.210(5) for workers employed in more than one job, were approved or denied; and

(d) A summary sheet for each claim showing all payments made, separated into disability, medical, and vocational assistance payments with cumulative totals. The record of disability payments should be limited to statutory benefits and not include any additional employer obligations. Expenses must not be included in any of the three columns required on the summary sheet. "Expenses" are defined in National Council on Compensation Insurance, Workers' Compensation Statistical Plan, Part IV.

(4) Records of a denied claim may be removed from this state after all the appellate procedures have been exhausted and the denial is final by operation of law.

(5) Records of any claim for a compensable injury may be removed from this state after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur.

(6) Notwithstanding sections (4) and (5) of this rule, if administrative or judicial review is requested, the claim records may not be removed from this state or disposed of until after either the review is concluded and the time for an appeal from such review has expired or at least one year after final payment of compensation has been made, whichever is the last to occur.

(7) During administrative or judicial review, if a denied claim is found to be compensable the records of the claim are subject to section (5) of this rule.

(8) The self-insured employer may destroy claim records when the self-insured employer can verify that all potential for benefits to the injured worker or the worker's beneficiaries is gone.

(9) Records retained as required by section (1) of this rule may be removed from the state or destroyed at the end of three full calendar years after the calendar year in which the money was remitted.

Stat. Auth: ORS 656.455, 656.704 and 656.726(4)
Stats. Implemented: ORS 656.455
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0230 Out-of-State Recordkeeping and Claims Processing by Self-Insured Employer; Conditions and Procedure for Permit; Revocation

(1) Notwithstanding OAR 436-050-0220, if a self-insured employer wishes to keep the claims records and process claims at a location outside this state, the employer may apply to the director for permission to do so. The application shall contain the reasons for the request and the location, mailing address, telephone number, and any other contact information where the records will be kept and the claims processed. The application must provide the director contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director. Upon receipt, the director will review the application and notify the employer that the request has been denied and the reason therefor; or, that the employer will be allowed to process claims from outside this state.

(2) The director may grant permission to the self-insured employer unless the employer has committed acts or engaged in a course of conduct that would be grounds for revocation of permission or that are contrary to any of the provisions of section (3) of this rule.

(3) A self-insured employer that keeps claims records and processes claims at a location outside this state must:

(a) Process claims in an accurate and timely manner;

(b) Make reports to the director promptly as required by ORS chapter 656 and the director's administrative rules;

(c) Pay to the director promptly all assessments and other money as it becomes due;

(d) Increase or decrease its security deposit promptly when directed to do so by the director under ORS 656.407(2); and

(e) Comply with the rules and orders of the director in processing and paying claims for compensation.

(4) After notice given as required by ORS 656.455(2), permission granted under this section will be revoked by the director if the employer has committed acts or engaged in a course of conduct that are in violation of any provisions of section (3) of this rule.

(5) A self-insured employer must provide written records which have been removed from this state to the director as requested within a reasonable time not to exceed 14 days or as otherwise negotiated.

Stat. Auth: ORS 656.455, 656.704 and 656.726(4)
Stats. Implemented: ORS 656.455
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0260 Qualifications of a Self-Insured Employer Group

Five or more employers may qualify as a self-insured employer group if the employers as a group:

(1) Incorporate or are a cooperative under ORS chapter 60, 62, or 65. If the group is a governmental subdivision, it must have formed a governmental entity as provided under ORS 190.003 to 190.110;

(2) Designate:

(a) A board of trustees; and

(b) An administrator, subject to section (10) of this rule;

(3) Demonstrate and maintain:

(a) A combined net worth of at least $3 million; and

(b) For private employer groups, individual member net worth of at least $150,000. Private employer groups must obtain annual financial data from all members regarding their individual fiscal year end net worth;

(4) Have excess insurance coverage of the type and amounts approved by the director, including a self-insured retention of at least $300,000;

(5) Demonstrate that accident prevention is likely to improve through self-insurance;

(6) Engage an adequate staff under OAR 436-055-0070 qualified to process claims;

(7) Develop a method approved by the director to notify the director of:

(a) The commencement or termination of membership by employers in the group, and the effect on the remaining combined net worth of the employers in the group; and

(b) Whether an employer who terminates membership in the group continues to be a subject employer; and if the employer remains a subject employer what arrangements have been made to continue coverage;

(8) Establish a safety and health loss prevention program as required by OAR 437-001;

(9) Create a common claims fund approved by the director;

(10) Designate an entity for the group responsible for centralized claims processing, payroll records, safety requirements, recording and submitting assessments and contributions and making such other reports as the director may require. For groups consisting of private employer members, the designated entity may not be a member of the group or the group's board, or a trustee for the group. With the approval of the director, a self-insured employer group may use service companies as authorized by ORS 656.455 instead of establishing its own place of business in this state. To obtain approval or to change or add service locations, the employer group must file with the director a copy of the agreement entered into between the employer group and each company, and must give the director notice of the location, mailing address, telephone number, and any other contact information of each service company;

(11) Establish proof of financial ability by:

(a) Providing a security deposit that the director determines is acceptable under OAR 436-050-0165 and in an amount determined under OAR 436-050-0180; and

(b) Demonstrating financial viability based on factors including, but not limited to:

(A) The group meeting the combined net worth requirements in section (3)(a) of this rule;

(B) For private employers that are members of a self-insured group, meeting the individual net worth requirements in section (3)(b) of this rule; and

(C) Demonstrating acceptable financial strength based on the total combined points for the group's financial ratios, in section (12) of this rule.

(12) Self-insured employer groups must demonstrate and maintain acceptable financial strength in the following three financial ratios. "Acceptable financial strength" means the group has total combined points for the three ratios equaling "strong" or "moderate" ratings, under section (13) of this rule.

(a) The current ratio equals current assets divided by current liabilities.

(A) For purposes of calculating this ratio:

(i) Current assets identified in the financial statements and reports provided annually to the director under OAR 436-050-0175(1) through (3) must reasonably be expected to be converted into cash, or could become the equivalent of cash, within one year in the normal course of business. Examples of such assets include readily available cash, investments, marketable securities, and bonds where maturity occurs within one year and their value upon conversion to cash is not reduced by penalties or fees, accounts receivable, inventory, and prepaid expenses. Current assets must not include fixed assets, accumulated depreciation, intangible assets, or investments, marketable securities, or bonds with maturity dates of one year or longer.

(ii) The face value of a self-insured group's irrevocable standby letter of credit (ISLOC) used to satisfy the director's requirement for a security deposit must not be included in the self-insured group's reported assets, since funds provided by an ISLOC are not construed to be an asset of the group under OAR 436-050-0165(2)(a)(J) and the required language in the ISLOC, Form 440-3640.

(iii) Current liabilities identified in the financial statements and reports provided annually to the director under OAR 436-050-0175(1) through (3) are obligations expected to be due within the next year. Examples of such liabilities include accounts payable, notes payable, accrued taxes, and wages and salaries owed to workers. Current liabilities must not include debts or claims on assets that will be due a year or more in the future or longer-term liabilities intended to provide more permanent funds for the business, including bank loans and long-term bonds.

(B) A maximum of six points are possible for this ratio, with a 2:1 ratio the desired standard. Points for the current ratio are determined as follows:

Ratio		Points
At least 2:1	=	6 points
At least 1.75:1	=	5 points
At least 1.6:1	=	4 points
At least 1.4:1	=	3 points
At least 1.25:1	=	2 points
At least 1.1:1	=	1 point
At least 1:1	=	0 points

(b) The liquidity ratio equals cash divided by current liabilities.

(A) For purposes of calculating this ratio:

(i) Cash identified in the financial statements and reports provided annually to the director under OAR 436-050-0175(1) through (3) must include all readily available funds such as bills, coin, or checking account balances. Cash funds exclude those held in special deposit or escrow accounts where some degree of legal constraint against their use exists.

(ii) Current liabilities identified in the financial statements and reports provided annually to the director under OAR 436-050-0175(1) through (3) are obligations expected to be due within the next year. Examples of such liabilities include accounts payable, notes payable, accrued taxes, and wages and salaries owed to workers. Current liabilities must not include debts or claims on assets that will be due a year or more in the future or longer-term liabilities intended to provide more permanent funds for the business, including bank loans and long-term bonds.

(B) A maximum of six points are possible for this ratio, with 40% the desired standard. Points for the liquidity ratio are determined as follows:

Ratio		Points
At least 50%	=	6 points

At least 40% = 5 points
At least 30% = 4 points
At least 25% = 3 points
At least 20% = 2 points
At least 10% = 1 point
At least 5% = 0 points

(c) The premium to surplus ratio equals earned contributions divided by the group's adjusted net worth.

(A) For purposes of calculating this ratio:

(i) Earned contributions identified in the financial statements and reports provided annually to the director under OAR 436-050-0175(1) through (3) are the net revenues from group members' contributions. Financial statements and reports may otherwise refer to this component as net premium, member contributions, or operating revenue. At the director's discretion, excess insurance premiums may be deducted from earned contributions when there is a reasonable likelihood of performance by the excess insurance carrier.

(ii) Adjusted net worth is the net worth identified in the certified statement provided annually to the director under OAR 436-050-0175(4)(a) less disallowed assets, which are prepaid expenses, inventory, and accounts receivable over 90 days old. Financial statements and reports may otherwise refer to net worth as net position, net assets, surplus, owner's equity, or shareholders' equity. The adjusted net worth is the total assets minus the sum of the total liabilities and the disallowed assets.

(B) A maximum of six points are possible for this ratio, with up to 1.00 the desired standard. Points for the premium to surplus ratio are determined as follows:

Ratio		Points
0.00 – 0.99	=	6 points
1.00 – 1.49	=	5 points
1.50 – 1.99	=	4 points
2.00 – 2.24	=	3 points
2.25 – 2.49	=	2 points
2.50 – 2.74	=	1 point
2.75 and over	=	0 points

(13) The sum of the three ratios equals a maximum of 18 points. That sum determines the rating for a self-insured employer group's financial strength and the potential consequences, as follows:

(a) 13 to 18 points: strong. Based on meeting all requirements of this rule, the director will approve initial or continued self-insured group certification. The group's security deposit amount will be determined based on OAR 436-050-0180 (1) through (3).

(b) 7 to 12 points: moderate. Based on meeting all requirements of this rule, the director will approve initial or continued self-insured group certification. The director will increase the security deposit amount calculated in OAR 436-050-0180 (1) through (3) by the percentage factor indicated for the sum of the group's ratio points, under section (4) of that rule.

(c) 0 to 6 points: weak. The director will not approve the application for initial self-insured employer group certification. For an existing certified self-insured employer group, the director may:

(A) Provide the group notice of the director's intent to revoke its self-insurance certification under OAR 436-050-0340(1); or

(B) Increase the security deposit calculated in OAR 436-050-0180 by an amount based on factors including, but not limited to:

(i) The considerations identified in OAR 436-050-0180(3); or

(ii) The determination that a financial correction plan submitted by the group demonstrates the ability to improve its financial viability sufficient to achieve the moderate financial rating in subsection (b) of this rule in a reasonable time period and without hampering the group's ability to pay compensation and other amounts due under ORS chapter 656.

(14) Comply with the requirements of OAR 436-050-0165, 436-050-0170, 436-050-0175, 436-050-0180, 436-050-195, 436-050-0200, 436-050-0205, 436-050-0210 and 436-050-0220. Failure to comply with these requirements will result in the actions prescribed in those rules.

(15) Every self-insured employer group must maintain at least one place of business in this state where the employer processes claims, keeps written records of claims and other records as required by OAR 436-050-0210 to 436-050-0220.

(16) Failure of a private employer that is a member of a self-insured employer group to maintain individual net worth of at least $150,000 will result in cancellation of that member's participation in the group, under OAR 436-050-0290.

(17) Failure of a certified self-insured employer group to maintain the qualifications required in this rule will result in revocation of the self-insured employer group's certification. The group will be given 30 days written notice of the intent to revoke the self-insured certification, to be effective 30 days from the date of receipt of the revocation notice. If the self-insured employer group complies with the qualification requirements within the 30-day period, the revocation will be canceled and the certification will remain in effect.

Stat. Auth: ORS 656.407, 656.430, 656.704 and 656.726(4)
Stats. Implemented: ORS 656.407 and 656.430
Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0270 Applying for Certification as a Self-Insured Employer Group: Private Employers

(1) Employers applying for certification as a self-insured employer group must submit:

(a) A complete "Application to Become a Self-Insured Employer Group: Private Employers" (Form 440-1867);

(b) Proof in the form of a certificate from the Secretary of State's Corporation Division showing the employer group as a corporation or cooperative;

(c) A copy of the bylaws or corporate minutes which include:

(A) Designation of specific individuals as trustees for the corporation or cooperative;

(B) Naming an administrator to administer the financial affairs of the group who may not be a member of the group or the group's board, or a trustee for the group; and

(C) The criteria utilized by the trustees and administrator when approving applications for new membership and requests for withdrawal by members of the group;

(d) A copy of the fidelity bond furnished to the group by the administrator or a copy of the comprehensive crime policy obtained by the group, in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities;

(e) A current financial statement of each member making application which shows individual net worth of at least $150,000 and taken collectively shows the following:

(A) A combined net worth of all members making application for coverage of at least $3 million; and

(B) Working capital in an amount establishing financial strength, liquidity, and viability of the business, based on OAR 436-050-0260;

(f) An individual report by employer showing the employer's payroll by class and description and loss information for the last four calendar years;

(g) A completed "Group Self-Insured Indemnity Agreement" (Form 440-1866), or another form authorized by the director, that jointly and severally binds each member for the payment of any compensation and moneys due to the director by the group or any member of the group. Government subdivisions do not need to submit this agreement;

(h) Evidence of a safety and health loss prevention program designed to demonstrate that accident prevention will improve due to self-insurance;

(i) Proof of an adequate staff qualified to process claims by:

(A) Employing and retaining at each claims processing location, at least one person that is actually involved in the claims processing function and is qualified in accordance with OAR 436-055-0070; or

(B) Contracting the services of one or more service companies that employ, at each claims processing location, at least one person that is qualified in accordance with OAR 436-055-0070 and is actually involved in the self-insured employer's claims processing. If one or more service companies are used, a service agreement between the employer group and each service company, that meets the requirements of OAR 436-050-0260(10), must be submitted for approval of the director;

(j) The type, retention and limitation levels of excess insurance the employers as a group are planning to obtain in accordance with OAR 436-050-0170;

(k) A procedure for notifying the director of:

(A) The commencement or termination of employers within the group and the effect on the remaining combined net worth of the group; and

(B) Arrangements made by an employer leaving the group to continue insurance coverage.

(L) A program whereby each employer within the group contributes to a common claims fund in accordance with OAR 436-050-0300; and

(m) The type of security deposit the employer group wishes to provide, with appropriate justification.

(2) Notwithstanding subsection (1)(e) of this rule, the director may require an audited financial statement before considering an application by a group for self-insurance.

(3) Within 60 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the employer group that the request for certification as a self-insured employer group is denied and the reason therefore; or, that the group is qualified as a self-insured employer group. The notice must include:

(a) The amount of security deposit required;

(b) Approval of the type, retention and limitation levels of the excess insurance as determined under OAR 436-050-0170; and

(c) The type, retention and limitation levels of excess insurance required.

(4) The certification of self-insurance will be issued upon receipt of the security deposit and the appropriate excess insurance binder.

(5) Unless a later date is specified by the applicant, the effective date of certification will be the first day of the month following the date the requirements of section (4) of this rule are met.

Stat. Auth: ORS 656.407, 656.430, 656.704 and 656.726(4)
Stats. Implemented: ORS 656.407 and 656.430
Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0280 Applying for Certification as a Self-Insured Employer Group: Governmental Subdivisions

(1) Governmental subdivisions applying for certification as a self-insured employer group must submit:

(a) An application for the group applying for self-insurance in a form and format prescribed by the director;

(b) Proof that the governmental subdivisions have formed an intergovernmental entity as provided under ORS 190.003 to 190.110;

(c) An intergovernmental agreement which includes:

(A) Designation of specific individuals as trustees for the group and naming an administrator to administer the financial affairs of the group; and

(B) The criteria to be used by the trustees and administrator when approving applications for new membership and requests for withdrawal by members of the group;

(d) A copy of the fidelity bond furnished to the group by the administrator or a copy of the comprehensive crime policy obtained by the group, in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities;

(e) A current financial statement of each member making application which taken collectively shows the combined net worth of all members making application for coverage must not be less than $3 million;

(f) An individual report by employer showing the governmental subdivision's payroll by class and description and loss information for the last four calendar years;

(g) A resolution by the governing body of each governmental subdivision binding it to be liable for the payment of any compensation and other amounts due to the director under ORS Chapter 656 incurred by that governmental subdivision during the period of group self-insurance;

(h) Evidence of a safety and health loss prevention program designed to demonstrate that accident prevention will improve due to self-insurance;

(i) Proof of an adequate staff qualified to process claims by:

(A) Employing and retaining at each claims processing location, at least one person that is actually involved in the claims processing function and is qualified in accordance with OAR 436-055-0070; or

(B) Contracting the services of one or more service companies that employ, at each claims processing location, at least one person that is actually involved in the self-insured group's claims processing, that is certified in accordance with OAR 436-055-0070. If service companies are used, a service agreement between the group and each service company, that meets the requirements of OAR 436-050-0260(10), must be submitted;

(j) The type, retention and limitation levels of excess insurance the employers as a group are planning to obtain in accordance with OAR 436-050-0170;

(k) A procedure for notifying the director of:

(A) The commencement or termination of governmental subdivisions within the group and the effect on the remaining combined net worth of the group; and

(B) Arrangements made by a governmental subdivision leaving the group to continue insurance coverage;

(L) A program whereby each employer within the group contributes to a common claims fund in accordance with OAR 436-050-0300; and

(m) The type and amount of security deposit the group wishes to provide, with appropriate justification. In no case will the amount be less than $300,000.

(2) Notwithstanding subsection (l)(e) of this rule, the director may require an audited or certified financial statement before considering an application by a group for self-insurance.

(3) Within 60 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the group that the request for certification as a self-insured employer group is denied and the reason therefore; or, that the group is qualified as a self-insured employer group. The notice must include:

(a) The amount of the security deposit required; and

(b) Approval of the type, retention and limitation levels of the excess insurance as determined under OAR 436-050-0170; and the type, retention and limitation levels of excess insurance required.

(4) The certification of self-insurance will be issued upon receipt of the security deposit, the appropriate excess insurance binder and if applicable, a service agreement between the employer and service company that has been signed by both parties.

(5) Unless a subsequent date is specified by the applicant, the effective date of certification will be the date the certification is issued.

Stat. Auth: ORS 656.407, 656.430, 656.704 and 656.726(4)
Stats. Implemented: ORS 656.407 and 656.430
Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0290 Commencement/Termination/Cancellation of Employers with a Self-Insured Employer Group; Effect on Net Worth; Extension of Coverage; Change in Entity; Change of Address; Recordkeeping

(1) Prospective new members of a self-insured employer group must submit an application to the board of trustees, or its administrator. The administrator of a group consisting of private employer members may not be a member of the group. The trustees, or administrator, may approve the application for membership under the bylaws of the self-insured group. Once approved, the administrator or board of trustees must submit to the director, within 30 days of the effective date of membership, a completed "Endorsement to Self-Insured Group Application" (440-1869) or a form approved by the director, which must be accompanied by:

(a) A current financial statement of the employer applying;

(b) Evidence of at least $150,000 individual net worth if the prospective new member is a private employer;

(c) An agreement signed by the administrator of the self-insured group and the employer, making the employer jointly and severally liable for the payment of any compensation and moneys due to the director by the group or any member of the group; or, if a governmental subdivision self-insured group, a resolution by the governing body of each governmental subdivision binding it to be liable for the payment of any compensation and other amounts due to the director under ORS Chapter 656 incurred by that governmental subdivision during the period of group self-insurance;

(d) A statement showing the effect on the new combined net worth of the group; and

(e) The employer's payroll by class and description and loss information for the last four fiscal or calendar years.

(2) Incomplete submissions or incorrectly completed endorsements to add new members received by the director will not be considered filed. Failure to file a correct and complete endorsement with the required supporting documentation within 30 days of the effective date of membership may result in the assessment of civil penalties.

(3) Individual members may elect to terminate their participation in a self-insured group or be subject to cancellation by the group under the bylaws of the group. Groups consisting of private employer members must also cancel the membership of any private employer member that fails to maintain the minimum individual net worth required, under OAR 436-050-0260 (16). Such cancellation must occur within 30 days of the group's receipt of the employer member's most recent fiscal year end financial data demonstrating insufficient net worth. The self-insured group must submit the following information to the director no later than 10 days before the effective date of the member's termination or cancellation:

(a) A statement, without disclaimers or qualifying language as to the accuracy of the information provided:

(A) Showing the effect of the member's termination or cancellation on the remaining combined net worth of the group; and

(B) Certifying that the group continues to meet the combined net worth requirements in OAR 436-050-0260;

(b) Evidence that the employer requesting termination or being cancelled has made alternate arrangements for coverage if the employer continues to employ;

(c) Evidence that the employer requesting termination or being cancelled has been provided a written reminder about its potential future liability as described in section (1)(c) of this rule; and

(d) The expected date of cancellation or termination.

(4) In the event the director determines the cancellation or termination of a group member adversely affects the net worth of the group to the extent that the group no longer qualifies for self-insurance certification, the director may revoke the self-insured employer group's certification under OAR 436-050-0340(3).

(5) An employer within a group must, if there is a change in the employing legal entity, again apply for membership within the group, in accordance with this rule. A change in legal entity includes, but is not limited to:

(a) When a partner joins or leaves the partnership;

(b) When the employer is a sole proprietorship, partnership, or corporation, and changes to a sole proprietorship, partnership, or corporation; or

(c) When an employer sells an existing business to another person(s), except in the case of a corporation.

(6) An employer within a group must, within 10 days after there is a change of address or assumed business name, notify the board of trustees or administrator of the change. The administrator or board of trustees must, within 10 days, submit to the director an endorsement as notice of the change. A change of address includes, but is not limited to:

(a) Establishment of a new or additional location; or

(b) Termination of an existing location.

(7) The endorsement required by section (6) of this rule must state specifically which location is being deleted or which is being added. It must also identify the type of address, whether it is mailing, operating, or the principal place of business.

(8) The employer group is responsible for maintaining coverage records relating to each member, to include:

(a) The employer's application for membership in the group, with original signatures;

(b) The employer's liability agreement under OAR 436-050-0270(1)(g), or resolution under OAR 436-050-0280(1)(g), with original signatures;

(c) Cancellation or termination notices;

(d) Reinstatement applications and notices; and

(e) Records on the whereabouts of employers that have been canceled or have terminated their participation in the group.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.434 and 656.440
Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0300 Self-Insured Employer Group, Common Claims Fund

(1) A self-insured employer group must establish, under the direction and control of the board of trustees and administrator, a common claims fund for the sole purpose of ensuring the availability of funds to make certain the prompt payment of all compensation and all other payments that may become due from such self-insured employer group under the workers' compensation law.

(2) The common claims fund must be maintained in an account held by an Oregon state chartered or a federally chartered bank. Government subdivisions certified as a self-insured employer group may also maintain the common claims fund in a "Local Government Investment Pool" account held by the Office of the State Treasurer.

(3) Except as provided in section (6) of this rule, the balance of the common claims fund must be maintained in an amount at least equal to 30 percent of the average of the group's paid losses for the previous four years. The full sum of the required common claims fund balance must be maintained at all times.

(4) The director may require the self-insured group to increase the amount maintained in the common claims fund.

(5) By March 1 of each year, a self-insured employer group must provide the director with adequate documentation to validate the balance in the common claims fund or notice that

the amount calculated in section (3) or (6) of this rule must be included in the determination of the self-insured employer group's security deposit under OAR 436-050-0180. The director may require a self-insured employer group to provide documentation of the common claims fund balance more frequently.

(6) For governmental subdivisions certified as a self-insured employer group, the balance of the common claims fund must be maintained in an amount at least equal to 60 percent of the average of the group's yearly paid losses for the previous four years.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.430
Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0340 Group Self-Insurance Revocation

Notwithstanding ORS 656.440, the certification of a self-insured employer group may be revoked by the director after giving 30 days notice if:

(1) The employer group does not comply with ORS 656.430(7) or (8) or OAR 436-050-0260, 0270, 0280, 0290, or 0300;

(2) There are fewer than five employers within a group;

(3) The net worth of the group falls below that required by OAR 436-050-0260(3);

(4) The employer group defaults in payment of compensation or other payments due the director;

(5) The employer group commits any violation for which a civil penalty could be assessed under ORS 656.745; or

(6) The employer group or any member of the group submits any false or misleading information.

Stat. Auth: ORS 656.704 and 656.726(4);
Stats. Implemented: ORS 656.434 and 656.440
Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0400 Responsibility for Providing Coverage under a Lease Arrangement

(1) Every worker leasing company providing workers to a client must satisfy the requirements of ORS 656.017, 656.407, or 656.419.

(2) Every worker leasing company providing leased workers to a client must also provide workers' compensation insurance coverage for any subject workers of the client, unless the client has an active workers' compensation insurance policy proof of coverage on file with the director or is certified under ORS 656.430 as a self-insured employer. In the latter circumstance, the client's insurer or the self-insured employer will be deemed to provide insurance coverage for all leased workers and subject workers of the client.

(3) If an insured client allows its workers' compensation insurance policy to cancel or does not obtain a renewal of the policy, or if a self-insured client allows its certification to terminate, and the client continues to employ subject workers or has leased workers, the client will be considered a noncomplying employer unless the worker leasing company has made the filing with the director under OAR 436-050-0410(1).

(4) A client can obtain leased workers from only one worker leasing company at a time unless the client has an active workers' compensation insurance policy proof of coverage on file with the director or is certified under ORS 656.430 as a self-insured employer.

(5) A worker leasing company must not provide workers' compensation coverage for another worker leasing company doing business in Oregon whether or not any of the worker leasing companies involved is licensed for worker leasing in Oregon.

(6) A client employer may not obtain workers by contract and for a fee on a non-temporary basis from an unlicensed worker leasing company.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855; **Stats. Implemented:** ORS 656.850 and 656.855
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0410 Notice to Director of Lease Arrangement; Termination

(1) Within 14 days after the effective date of the lease arrangement or contract, a worker leasing company must file written notice with the director and its insurer, using Form 440-2465, that it is providing leased workers to a client and workers' compensation coverage. The notice must be correct and complete, and must include:

(a) The client's:

(A) Legal name;

(B) FEIN or other tax reporting number;

(C) Type of ownership;

(D) Primary nature of business;

(E) Mailing address; and

(F) Street address in Oregon;

(b) The worker leasing company's:

(A) Legal name;

(B) Mailing address;

(C) FEIN or other tax reporting number;

(D) WCD worker leasing license number, if any;

(E) Workers' compensation insurer's name (or "self-insured");

(F) Effective date of leasing contract;

(G) Contact name and phone number; and

(H) A signature of a representative of the worker leasing company.

(2) A worker leasing company may terminate its obligation to provide workers' compensation coverage by giving to its insurer, its client, and the director written notice of the termination. A notice of termination must state the effective date and hour of termination, but the termination will be effective not less than 30 days after the notice is received by

the director. Notice to the client under this section must be given by mail, addressed to the client at its last-known address.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855
Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0420 Temporary Worker Distinguished from Leased Worker

(1) A person who provides a worker to work for a client will be considered to be providing the worker on a "temporary basis" only if there is contemporaneous written documentation that indicates the duration of the work to be performed and that the worker is provided for a client's special situation under ORS 656.850(1)(b). Contemporaneous documentation means documents that are created at the time the temporary service provider and the client employer make the arrangements for placement of the worker. Upon the director's request, the documentation must be provided to the director by either the temporary service provider or the client. Contemporaneous documentation in support of workers being provided on a temporary basis includes one or more of the following conditions:

(a) To cover employee absences or employee leaves, including but **n**ot limited to such things as maternity leave, vacation, jury duty, or illness from which the permanent worker will return to work;

(b) To fill a professional skill shortage, including but not limited to, professionals such as engineers, architects, electricians, plumbers, pharmacists, nurses, or other professions, whether licensed or not, to supplement or satisfy a shortage of that skill for a known duration. Supporting documentation may include license information and whether the worker is supplementing or satisfying a client employer's need for the skill;

(c) To staff a seasonal or sporadic increase in workload, indicated by a temporary increase in demand upon an employer's normal workload that requires additional assistance to meet the demand. When the increased demand ends, the additional positions are eliminated. Documentation must include what constitutes the demand establishing why this special situation is beyond the norm;

(d) To staff a special assignment or project outside of the routine activities of the business where the worker will be terminated or assigned to another temporary project upon completion. For example, a construction contractor may need assistance on a construction site to help clear branches and other debris after a windstorm so the regular construction crew can continue its work. Documentation must describe the project and why it is unusual;

(e) To hire a student worker that will be provided and paid by a school district or community college through a work experience program. Documentation must include the name of the school and the work experience program; or

(f) To cover special situations where the worker has a reasonable expectation of transitioning to permanent employment with the client employer and the client employer uses a pre-established probationary period in its overall employment selection program. Documentation must include copies of the client employer's written program or other evidence supporting the pre-established probationary period and overall employment selection program.

(2) If a person provides workers, by contract and for a fee, to work for a client and any such workers are not provided on a "temporary basis," that person will be considered a worker leasing company.

(3) If a person provides both leased workers and workers on a temporary basis, that person must maintain written records that show specifically which workers are provided on a temporary basis. If the written records do not specify which workers are provided on a temporary basis, all workers are deemed to be leased workers.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855
Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0440 Qualifications, Applications, and Renewals for License as a Worker Leasing Company

(1) Each person applying for initial license or renewal as a worker leasing company must:

(a) Be either an Oregon corporation or other legal entity registered with the Oregon Secretary of State, Corporations Division to conduct business in this state;

(b) Maintain workers' compensation coverage under ORS 656.017; and

(c) Upon application approval and prior to licensure, pay the required licensing fee of $2,050.

(2) Each person applying for initial license or renewal as a worker leasing company must submit an Application for Oregon Worker Leasing License Form 440-2466. The form and accompanying documentation must include:

(a) Legal name;

(b) Mailing address;

(c) In-state and out-of-state phone numbers;

(d) FEIN or other tax reporting number;

(e) Type of business;

(f) Physical address for Oregon principal place of business;

(g) Assumed business names;

(h) Name of workers' compensation insurer (or "self-insured") and policy number;

(i) Name(s) and contact information of the representative(s) at the Oregon location(s);

(j) List of controlling persons, and in the case of privately held entities all owners, including their names, titles, residence addresses, telephone numbers, email addresses, and dates of birth;

(k) For a person applying for an initial license, a list of all states where the person operates as a leasing company or professional employer organization (PEO), copies of licenses,

registrations, recognitions, or certifications from states that require those actions, and a verifiable statement that the remaining states of operation, if any, do not require licensure, registration, recognition, or certification to provide worker leasing or PEO services;

(l) Verification of compliance with tax laws from Oregon Employment Department, Oregon Department of Revenue, and the Internal Revenue Service, using Attachments A, B, and C of Form 440-2466, the worker leasing license application;

(m) A record of any present or prior experience of providing workers by contract and for a fee in any state, by the person or any controlling person, and an explanation of that experience;

(n) A record of any bankruptcies, liens, or any actions involving or demonstrating dishonesty or misrepresentation, including but not limited to: fraud, theft, burglary, embezzlement, deception, perjury, forgery, counterfeiting, bribery, extortion, money laundering, or securities, investments, or insurance violations on the part of the person or any controlling person. Records of such actions must include:

(A) Charges, guilty pleas, or pleas of no contest;

(B)Criminal convictions;

(C)Lawsuits;

(D) Judgments; or

(E) Discharges or permitted resignations based on allegations of these actions.

(o) Full details regarding any bankruptcy, liens, or action under subsection (n) of this section, including:

(A) The nature and dates of the action(s);

(B) Outcomes, sentences, and conditions imposed;

(C) Name and location of the court or jurisdiction in which any proceedings were held or are pending, and the dates of the proceedings; and

(D) The designation and license number for any actions against a license;

(p) Full details of any administrative actions against the person by a regulatory agency of any state regarding matters listed in subsection(2)(n) or worker leasing activities;

(q) A plan of operation that demonstrates how the worker leasing company will meet the requirements of ORS chapter 654, The Oregon Safe Employment Act;

(r) A plan of operation that demonstrates how the worker leasing company will collect and report the information necessary to establish each client's separate experience rating to the insurer providing workers' compensation coverage for each client, or to the National Council on Compensation Insurance for a self-insured worker leasing company and

(s) A notarized signature of an authorized representative of the applicant.

(3) The director may request additional information to further clarify the information and documentation submitted with the application. Under ORS 656.850(2), no person may perform services as a worker leasing company in Oregon without first being licensed to do so.

(4) The director will review complete applications, and may conduct a background investigation of the person applying for a license, an owner, or any controlling person. Information learned through a background investigation, or other information submitted during the application process, may be the basis for the director to refuse to issue or renew a license, or to disqualify the person from making further application.

(5) If the application is approved, the director will issue a license. Each license issued under these rules will automatically expire two years after the date of issuance unless renewed by the licensee. To renew a license, the worker leasing company must submit a renewal application to the director at least 90 days before the expiration of the current worker leasing license. Any supplemental material, whether requested by the director or submitted by the worker leasing company to establish a complete application, must be received by the director at least 45 days before expiration of the current license.

(6) The director may refuse to issue or renew a license or may disqualify a person, controlling person, or worker leasing company from applying for a license in the future for misrepresentation, failure to meet any of the requirements of ORS 656.850, 656.855, or these rules, or for reasons including, but not limited to:

(a) Denial of a previous application for, or prior suspension or revocation of, a worker leasing license by the director;

(b) Denial, suspension, or revocation of a license, registration, or certification, or other discipline by any governmental agency or entity;

(c) Having exercised authority, control, or decision-making responsibility concerning any worker leasing company at the time that company had its authorization to provide worker leasing services denied, suspended, revoked, or restricted;

(d) Having been the subject of an order, adverse to the person, controlling person, or worker leasing company, by any governmental agency or entity in connection with any worker leasing activity;

(e) Having been found by any governmental agency or entity to have made a false or misleading statement, material misrepresentation, or material omission, or to have failed to disclose material facts;

(f) Violations of worker leasing statutes or regulations;

(g) Failure to establish minimum experience, training, or education that demonstrates competency in providing worker leasing services;

(h) Having been the subject of a complaint, investigation, or proceeding related to an action in subsection (2)(n) of this rule;

(i) Having been charged with, convicted of, or pleaded guilty or no contest to any felony or misdemeanor specified in subsection (2)(n) of this rule; or

(j) Having failed to provide documents the director has requested.

(7) "Disqualification," as used in this rule, means a person or a prospective worker leasing company may reapply no sooner than two years from the disqualification date.

(8) A disqualification may apply to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company's assets to another person, owner, or controlling person.

(9) A person may appeal the director's refusal to approve and issue or renew a license, or a disqualification, under this rule as provided in OAR 436-050-0008 and OAR 436-001.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855
Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0450 Recordkeeping and Reporting Requirements

(1) Every licensed worker leasing company must give notice to the director of one Oregon location where Oregon leasing records are kept and made available for review by the director. The notice must include the physical address, mailing address, telephone number, and any other contact information in this state.

(2) Every licensed worker leasing company must have at least one representative of the worker leasing company at the Oregon location authorized to respond to inquiries and make records available by the date specified in the director's request or demand for information regarding leasing arrangements and client contracts.

(3) The following records must be kept and made available for review at the Oregon location:

(a) Copies of signed worker leasing notices for the most recent three years;

(b) Copies of signed notices of termination of leasing arrangements for the most recent three years;

(c) Copies of signed contracts between the worker leasing company and clients for the most recent three years; and

(d) Payroll records for the most recent seven years for all workers that identify leased workers subject to coverage by the worker leasing company; leased workers not subject to coverage by the worker leasing company; and, written records for all regular and temporary employees of the worker leasing company.

(4) The worker leasing company must notify the director within 30 days of the effective date of a change in any items listed in OAR 436-050-0440(2).

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855
Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0455 Reporting Requirements of a Self-Insured Worker Leasing Company

(1) A self-insured worker leasing company must maintain and report to the National Council on Compensation Insurance separate statistical data for each client whose coverage is provided by the self-insured employer. Reporting must be according to the uniform statistical plan prescribed by the director according to ORS 737.225(4).

(2) Records relating to the client statistical data for self-insured worker leasing companies must be made available for review by the National Council on Compensation Insurance upon request.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855
Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0460 Suspension or Revocation of License

(1) Reasons for suspension or revocation of a worker leasing license include, but are not limited to:

(a) Insolvency, whether the worker leasing company's liabilities exceed their assets or the worker leasing company cannot meet its financial obligations;

(b) Judgments against or convictions, within the last ten years, of any worker leasing company or controlling person for the reasons identified in OAR 436-050-0440(2)(n);

(c) Administrative actions involving worker leasing activities resulting from failure to comply with the requirements of any state;

(d) Nonpayment of taxes, fees, assessments, or any other monies due the State of Oregon;

(e) If the worker leasing company or controlling person has failed to comply with any provisions of ORS chapters 654, 656, 659, 659A, 731 or 737; or any provisions of these rules; or

(f) If the worker leasing company or controlling person is permanently or temporarily enjoined by a court from engaging in or continuing any conduct or practice involving any aspect of the worker leasing business.

(2) For the purposes of this rule:

(a) "Suspension" means a stopping by the director of the worker leasing company's or controlling person's authority to provide leased workers to clients for a specified period of time. A suspension may be in effect for a period of up to two years. When the suspension expires, the worker leasing company or controlling person may petition the director to resume its worker leasing company activities.

(b) "Revocation" means a permanent stopping by the director of the worker leasing company's or controlling person's authority to provide leased workers to clients. After a revocation has been in effect for five years or longer, the worker leasing company or controlling person may reapply for license.

(c) "Show-cause hearing" means an informal meeting with the director in which the worker leasing company will be provided an opportunity to be heard and present evidence regarding any proposed actions by the director to suspend or revoke a worker leasing company's authority to provide leased workers to clients.

(3) The director may revoke a license upon discovery of a misrepresentation in the information submitted in the worker leasing application.

(4) Suspension or revocation under this rule will not be made until the worker leasing company has been given notice and the opportunity to be heard through a show-cause hearing before the director and "show cause" why it should be permitted to continue to be licensed as a worker leasing company.

(5) A show-cause hearing may be held at any time the director finds that a worker leasing company has failed to comply with its obligations under a leasing contract or that it failed to comply with the rules or orders of the director.

(6) Appeal of proposed and final orders of suspension or revocation issued under this rule may be made as provided in OAR 436-050-0008 and OAR 436-001.

(7) Notwithstanding section (4) of this rule, the director may immediately suspend or refuse to renew a license by issuing an "emergency suspension order" if the worker leasing company fails to maintain workers' compensation coverage; or if the director finds there is a serious danger to public health or safety.

(8) A suspension or revocation may apply to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company's assets to another person.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855
Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0470 Monitoring/Auditing

(1) The division will monitor and conduct periodic audits of employers as necessary to ensure compliance with the worker leasing company licensing and performance requirements.

(2) All pertinent records of the worker leasing company required by these rules must be disclosed upon request of the director.

(3) Under ORS 656.726 and 656.758, the director may inspect the books, records and payrolls of employers pertinent to the administration of these rules. Employers must provide the director with all pertinent books, records and payrolls upon request.

(4) For the purposes of this rule, both the worker leasing company and its clients will be considered employers.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855
Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-050-0480 Assessment of Civil Penalties

(1) Failure to provide timely notice to the director for proof of coverage and cancellation of workers' compensation insurance policies under ORS 656.419 or OAR 436-162, or failure to provide timely worker leasing notice to the director under ORS 656.850(5) and OAR 436-050-0410, may result in civil penalties under ORS 656.745.

(2) The director may assess a civil penalty under ORS 656.745 against an employer who fails to respond to requests for information or fails to meet the requirements of 436-050-0470. Assessment of a penalty does not relieve the employer of the obligation to provide a response.

(3) An employer failing to meet the requirements set forth in OAR 436-050-0410, 436-050-0450, and 436-050-0455, may be assessed a civil penalty under ORS 656.745.

(4) An employer who is found to be operating a worker leasing company without having obtained a license or after having failed to renew a license, or who continues to operate in Oregon as a worker leasing company after a prior Oregon license expired, may be assessed a civil penalty for each violation under ORS 656.745.

(5) For the purposes of ORS 656.850(2), a violation is defined as any month or part of a month for each client in which an employer provides leased workers to a client without having first obtained a worker leasing license.

(6) An employer obtaining workers by contract and for a fee from an unlicensed worker leasing company on a non-temporary basis may be subject to penalties under ORS 656.745. Upon a subsequent or continuing violation where written notice of such violation has been served, penalties under ORS 656.745 will be assessed against the employer.

(7) Any person or controlling person may also be subject to penalties under ORS 656.990.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855;
Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.
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OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 055

CERTIFICATION OF CLAIMS EXAMINERS

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436-055-0001 Authority for Rules

These rules are promulgated under the director's authority pursuant to ORS 656.726 and 656.780.

Stat. Auth.: ORS 656.726(3)(a) and ORS 656.780(1)
Hist.: Amended 7/14/94 as WCD Admin. Order 94-054, eff. 9/1/94
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-055-0002 Purpose of Rules

The purpose of these rules is to establish standards for the certification of workers' compensation claims examiners pursuant to ORS Chapter 656.

Stat. Auth.: ORS 656.780(1)
Hist.: Amended 12/21/99 As WCD Admin. Order 99-063, eff. 01/01/00
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-055-0003 Applicability of Rules

(1) These rules apply to the certification of all workers' compensation claims examiners on or after the effective date of these rules.

(2) The certification of any workers' compensation claims examiner valid on December 31, 1999 shall continue without expiration until December 31, 2000. However, this provision does not shorten any two year certification period.

(3) Any claims examiner certified on October 22, 1999, with a renewal date between October 23, 1999 and December 31, 1999, may present records to the insurer for renewal. The claims examiner's certification period shall be renewed for two years upon verification that the certified claims examiner met the continuing education requirements under the rules in effect on the date renewal was due, however no course taken after October 22, 1999 needs to be certified.

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

Stat. Auth.: ORS 656.780
Hist.: Amended 12/21/99 As WCD Admin. Order 99-063, eff. 01/01/00
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-055-0005 Definitions

Except where the context requires otherwise, these rules are governed by the following definitions:

(1) "Claims examiner" means anyone who has primary responsibility for decision making or benefit determination in a claim. This includes those who decide compensability of new claims or aggravations, calculate benefits, authorize payments, or who represent employers by direct contact with the department or Board. This definition does not include attorneys representing employers before the department or Board, or those who primarily perform clerical functions.

(2) "Claims Examiner Trainee" means a person hired by an insurance company, self-insured employer or third party administrator to decide compensability of new claims or aggravations, calculate benefits, or authorize payments, who works under the direct supervision of a certified claims examiner.

(3) "Director" means the director of the Department of Consumer and Business Services or the director's designee.

(4) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in this state; an assigned claims agent selected by the director under ORS 656.054; an employer certified under ORS 656.430 that meets the qualifications of a self-insured employer under ORS 656.407; or a third party administrator.

(5) "Party" includes anyone listed in ORS 656.005(21) and a third party administrator.

(6) "Process Claims" means the receipt, review and payment of compensation for workers' claims.

(7) "Temporary Claims Examiner" means a person with at least two years of prior claims processing experience hired by an insurance company, self-insured employer or service company to decide compensability of new claims or aggravations, calculate benefits, or authorize payments in Oregon workers' compensation claims, who works under the direct supervision of a certified claims examiner.

(8) "Third party administrator" means a service company who processes claims for an insurer or self-insurer under the conditions prescribed in ORS 731.475(3) and ORS 656.455(1).

Stat. Auth.: ORS 656.726(3)(a)
Hist.: Amended 12/21/99 As WCD Admin. Order 99-063, eff. 01/01/00
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-055-0008 Administrative Review

(1) Any party that disagrees with a proposed order or proposed assessment of civil penalty of the director issued under ORS 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740. The request for hearing must be mailed or delivered to the Administrator of the Workers' Compensation Division by the aggrieved person within 60 days after the mailing date of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested.

(2) Under ORS 656.704(2), any party that disagrees with an action or order of the director under these rules, other than as described in section (1), may request a hearing by filing a hearing request as provided in OAR 436-001-0019 within 60 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

(3) Any person that disagrees with an action taken under these rules by another person, except as described in sections (1) and (2), may request administrative review by the director as follows:

(a) The request for administrative review must be mailed or delivered to the Administrator of the Workers' Compensation Division within 90 days of the action. The request must specify the grounds upon which the action is contested.

(b) The review will be conducted by the director.

(c) The director will review the relevant information submitted by all parties.

(d) The director will issue an administrative order that specifies whether the determination constitutes a final order or whether an aggrieved party may request a hearing under section (2).

Stat. Auth.: ORS 656.735(5) through (7); ORS 656.745(4); ORS 656.726(4)
Stats. Implemented: ORS 656.740, ORS 656.726
Hist.: Amended 6/15/06 as WCD Admin. Order 06-055, eff. 7/1/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-055-0070 Certification of Claims Examiners

(1) Claims examiners shall be certified by the insurer upon satisfactory completion of an examination which demonstrates the individual's:

(a) Familiarity with the workers' compensation statutes;

(b) Ability to navigate the administrative rules found in this chapter;

(c) Capability to perform claim processing activities; and

(d) Understanding of activities related to interactions with independent medical examination providers that includes all the components in OAR 436-055-0085(2).

(2) Any person taking an examination may use a copy of ORS Chapter 656 and the Oregon Administrative Rules during the examination.

(3) A passing score on an examination shall be 80 percent or greater.

(4) Any examination completed through dishonest or fraudulent means shall be considered invalid.

(5) Certification will be for a three-year period. The certification date shall be the date of the examination.

(6) Certification shall be renewed at any time during the certification period by providing verification of completion of 24 hours of training during the current certification period, to include at least:

(a) Four hours of training on the workers' compensation statutes, administrative rules, and case law since the last certification; and

(b) For renewals on or after January 1, 2007, three hours of training related to interactions with independent medical examination providers that covers all the components in OAR 436-055-0085(2). The three hours of training may be completed in increments.

(7) Training may be provided in the form of a seminar, workshop, association meeting, forum, correspondence, video or similar course. It may include any of the following subjects:

(a) Medical case management including, but not be limited to, medical terminology, basic human anatomy and interpreting medical reports.

(b) Communication skills including, but not be limited to, courses in ethics, mediation, negotiation and dealing with angry people.

(c) Instruction dealing specifically with the processing of Oregon workers' compensation claims.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.780(1)
Hist.: Amended 6/15/06 as WCD Admin. Order 06-055, eff. 7/1/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-055-0085 Training for Interactions with Independent Medical Examination Providers

(1) Any training provided under OAR 436-055-0070 or OAR 436-055-0100(4) relating to independent medical examination provider interaction must first be approved by the director.

(2) To be approved, a training curriculum for initial certification must incorporate the following components:

(a) Appropriate and ethical communication with independent medical examination providers;

(b) Insurers' rights and responsibilities;

(c) Injured workers' rights and responsibilities;

(d) Independent medical examination providers' standards of conduct requirement;

(e) IME complaint process and investigations by WCD; and

(f) Training specific to the requirements of ORS 656.325 and OAR 436-010.

(3) To be approved, a training curriculum for renewal of certification must incorporate some or all of the components in (2).

(4) Any person may develop training and receive approval by the director by submitting an application in a format prescribed by the director. The application must describe the training content that meets the criteria in section (2) of this rule, and specify the number of training hours for that topic.

(5) The director's approval will remain in effect until the content or number of hours of training change. At that time, the person will be required to resubmit an application that meets the requirements of sections (2) and (4) or (3) and (4) of this rule.

(6) The division will review an application and notify the applicant of the results within 30 days of receipt of the application. The division will reject incomplete applications.

(7) If an application is rejected or disapproved, the applicant will be notified of the reasons. The application may be resubmitted when the reasons for the rejection or disapproval have been corrected.

(8) The director will maintain a registry of approved training curricula.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.780(1)
Hist.: Amended 6/15/06 as WCD Admin. Order 06-055, eff. 7/1/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-055-0100 Insurer Duties

(1) Insurers shall only employ claims examiners who are certified or that qualify as a claims examiner trainee or a temporary claims examiner.

(a) A claims examiner trainee must work under the direct supervision of a certified claims examiner, and may work for up to12 months in this status. An individual is limited to one12-month period as a claims examiner trainee.

(b) A temporary claims examiner must have at least two years prior claims processing experience and work under the direct supervision of a certified claims examiner. An individual may work for up to 90 days in any 12-month period as a temporary claims examiner.

(2) Insurers shall maintain a list of certified claims examiners who are employed by the insurer or who process claims for the insurer, claims examiner trainees and temporary claims examiners, and keep records sufficient to verify their certification and training. The list and records shall be subject to inspection by the director. The director may require submission of such lists and records in lieu of on-site inspection.

(3) Insurers may issue an initial certification or renewal for any individual pursuant to the standards set in OAR 436-055-0070.

(4) Insurers must ensure that training related to interactions with independent medical examination providers is provided for certified claims examiners in their employ.

(5) Insurers shall not misrepresent any information to a worker, employer or the director related to the certifications of its employees.

(6) Within 14 days of the termination of employment or upon receipt of a written request of a certified claims examiner, an insurer shall provide the certified claims examiner a complete copy of all records verifying the most recent acknowledgement of certification and any subsequent training.

(7) Insurers shall retain records verifying the certification and renewal of certified claims examiners who are employed by the insurer or who process claims for the insurer for six years from its most recent acknowledgement of current certification.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.780(1) and (2)
Hist.: Amended 12/5/05 as WCD Admin. Order 05-076, eff. 1/1/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-055-0110 Assessment of Civil Penalties

(1) Under ORS 656.745 the director may assess a civil penalty against an insurer which fails to comply with these rules.

(2) Under ORS 656.780 the director may assess a civil penalty against an insurer that fails to maintain or produce certification and training records or that employs anyone other than certified workers' compensation claims examiner to process workers' compensation claims. The insurer shall be subject to a penalty of not more than $2000 per violation. Each violation, or each day a violation continues, shall be considered a separate violation.

Stat. Auth.: ORS 656.447(1)(a); ORS 656.745(2)(b); ORS 656.780(3)
Hist.: Amended 6/15/06 as WCD Admin. Order 06-055, eff. 7/1/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 060

CLAIMS ADMINISTRATION

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436-060-0001 Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.210(2), 656.262(11), 656.264, 656.265(6), 656.325, 656.331, and 656.726(4).

Stat. Auth.: ORS 656.210(2), 656.262(11), 656.264, 656.265(6), 656.325, 656.331, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.210(2), 656.262(11), 656.264, 656.265(6), 656.325, 656.331, 656.704, and 656.726(4)
Hist.: Amended 11/30/01 as WCD Admin. Order 01-061, eff. 1/1/02
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0002 Purpose

The purpose of these rules is to prescribe uniform standards by which insurers shall process workers' compensation claims under ORS 656.726(4). The director has charged the Workers' Compensation Division with the administration and enforcement of the applicable statutes, these rules, and all bulletins pertaining to claims processing. Failure to process claims in accordance with these rules will subject insurers to civil penalty under ORS 656.745; to penalties payable to the claimant under ORS 656.262(11); and, to sanctions under ORS 656.447.

Stat. Auth.: ORS 656.262(11), 656.447, 656.704, 656.726(4), and 656.745
Stats. Implemented: ORS 656.262(11), 656.447, 656.704, 656.726(4), and ORS 656.745
Hist.: Amended 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0003 Applicability of Rules

(1) These rules govern claims processing and 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;

(d) ORS 656.262. Responsibility for processing and payment of compensation, sight drafts, claimant's duty to cooperate with an investigation, acceptance and denial and reporting of claims, and penalties for payment delays;

(e) ORS 656.264. Required reporting of information to the director;

(f) ORS 656.265. Notices of accidents from workers;

(g) ORS 656.268. Insurer claim closures, insurer recovery of overpayments;

(h) ORS 656.273 Aggravation for worsened conditions, procedures, limitations, additional compensation;

(i) ORS 656.277 Request for reclassification of nondisabling claim, nondisabling claim procedure;

(j) ORS 656.307. Determination of responsibility for compensation payments;

(k) ORS 656.325. Required medical examinations, suspension of compensation, injurious practices, claimant's duty to reduce disability, and reduction of benefits for failure to participate in rehabilitation;

(l) ORS 656.331. Notice to worker's attorney; and,

(m) ORS 656.726(4). The director's powers and duties generally.

(2) The applicability of these rules is subject to ORS 656.202.

(3) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.210, 656.212, 656.230, 656.262, 656.264, 656.265, 656.268, 656.273, 656.277, 656.307, 656.325, 656.331, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.704 and 656.726(4)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0005 Definitions

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

(1) "Aggravation" means an actual worsening of the compensable condition(s) after the last award or arrangement of compensation, that is established by medical evidence supported by objective findings, and otherwise satisfies the statutory requirements of ORS 656.273.

(2) "Authorized nurse practitioner" means a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010.

(3) "Designated Paying Agent" means the insurer temporarily ordered responsible to pay compensation for a compensable injury under ORS 656.307.

(4) "Director" means the Director of the Department of Consumer and Business Services or the director's designee, unless the context requires otherwise.

(5) "Disposition" or "claim disposition" means the written agreement under ORS 656.236 in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794, except for medical services, in an accepted claim. The term "compromise and release" has the same meaning.

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

(7) "Employer" means a subject employer under ORS 656.023.

(8) "Employment on call" means sporadic, unscheduled employment at the call of an employer without recourse if the worker is unavailable.

(9) "Health insurance," under ORS 731.162, means all insurance against bodily injury, illness or disability, and the resultant expenses, except for workers' compensation coverage.

(10) "Inpatient" means an injured worker who is admitted to a hospital before and extending past midnight for treatment and lodging.

(11) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in Oregon; or, an employer or employer group certified under ORS 656.430 that it meets the qualifications of a self-insured employer under ORS 656.407.

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

(13) "Physical rehabilitation program" means any services provided to an injured worker to prevent the injury from causing continuing disability.

(14) "Service company" means the contracted agent for an insurer authorized to process claims and make payment of compensation on behalf of the insurer.

(15) "Suspension of compensation" means:

(a) No temporary disability, permanent total disability, or medical and related service benefits will accrue or be payable during the period of suspension; and

(b) Vocational assistance and payment of permanent partial disability benefits will be stayed during the period of suspension.

(16) "Written" and its variations mean that which is expressed in writing, including electronic transmission.

Stat. Auth.: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.704 and 656.726(4)
Hist.: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0006 Administration of Rules

Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and these rules are considered orders of the director.

Stat. Auth.: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.704 and 656.726(4)
Hist.: Amended 10/2/02 as WCD Admin. Order 02-059, eff 11/1/02
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0008 Administrative Review and Contested Cases

(1) Any party as defined by ORS 656.005, including an assigned claims agent as a designated processing agent under ORS 656.054, aggrieved by an action taken under these rules in which a worker's right to compensation or the amount thereof is directly in issue, 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 Law except where otherwise provided in ORS chapter 656.

(2) Contested case hearings of Sanctions and Civil Penalties: Any party as described in section (1) aggrieved by a proposed order or proposed assessment of civil penalty of the director issued under ORS 656.254, 656.735, 656.745 or 656.750 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

(a) The request for hearing must be sent in writing to the Administrator of the Workers' Compensation Division. No hearing will be granted unless the request specifies the grounds upon which the person requesting the hearing contests the proposed order or assessment.

(b) The aggrieved person must file a hearing request with the Administrator of the Workers' Compensation Division within 60 days after the mailing of the proposed order or assessment. No hearing will be granted unless the request for hearing is mailed or delivered to the administrator within 60 days of the mailing date of the proposed order or assessment.

(3) Hearings before an administrative law judge: Under ORS 656.704(2), any party that disagrees with an action or order of the director under these rules, other than as described in section (2), may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

(4) Administrative review by the director or designee: Any party aggrieved by an action taken under these rules by another person except as described in sections (1) through (3) above may request administrative review by the division on behalf of the director. The process for administrative review of such matters will be as follows:

(a) The request for administrative review must be made in writing to the Administrator of the Workers' Compensation Division within 90 days of the action. No administrative review will be granted unless the request specifies the grounds upon which the action is contested and is mailed or delivered to the administrator within 90 days of the contested action unless the director or the director's designee determines that there was good cause for delay or that substantial injustice may otherwise result.

(b) In the course of the review, the division may request or allow such input or information from the parties that the division deems helpful.

Stat. Auth.: ORS 656.704, 656.726(4), and 656.745
Stats. Implemented: ORS 656.245, 656.260, 656.704, 656.726(4), and 656.740(1)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0009 Access to Department of Consumer and Business Services Workers' Compensation Claim File Records

(1) Under ORS 192.430 and OAR 440-005-0015(1) the director, as custodian of public records, promulgates this rule to protect the integrity of claim file records and prevent interference with the regular discharge of the department's duties.

(2) The department rules on Access of Public Records, Fees for Record Search and Copies of Public Records are found in OAR 440-005. Payment of fees for access to records must be made in advance unless the director determines otherwise. Workers and insurers of record, their legal representatives and service companies shall receive a first copy of any document free. Additional copies shall be provided at the rates set forth in OAR 440-005.

(3) Any person has a right to inspect nonexempt public records. The statutory right to "inspect" encompasses a right to examine original records. It does not include a right to request blind searches for records not known to exist. The director will retain or destroy records according to retention schedules published by the Secretary of State, Archives Division.

(4) Under ORS 192.502(20) workers' compensation claims records are exempt from public disclosure. Access to workers' compensation claims records will be granted at the sole discretion of the director in accordance with this rule, under the following circumstances:

(a) When necessary for insurers, self-insured employers and service companies and their legal representatives for the sole purpose of processing workers' compensation claims. The division will accept a request by telephone or facsimile transmission, but such request must include the claimant's social security number and insurer claim number in addition to the information required in section (7).

(b) When necessary for the director, other governmental agencies of this state or the United States to carry out their duties, functions or powers.

(c) When the disclosure is made in such a manner that the disclosed information cannot be used to identify any worker who is the subject of a claim. Such circumstances include when workers' compensation claims file information is required by a public or private research organization in order to contact injured workers in order to conduct its research. The director may enter into such agreements with such institutions or persons as are necessary to secure the confidentiality of the disclosed records.

(d) When a worker or the worker's representative requests review of the workers' claim record.

(5) The director may release workers' compensation claims records to persons other than those described in section (4) when the director determines such release is in the public interest.

(a) For the purpose of these rules, a "public interest" exists when the conditions set forth in ORS 192.502(20) and subsections (4)(a) through (d) of this rule have been met. The determination whether the request to release workers' compensation claims records meets those conditions shall be at the sole discretion of the director.

(b) The director may enter into written agreements as necessary to ensure that the recipient of workers' compensation claims records under this section uses or provides the information to others only in accordance with these rules and the agreement with the director. The director may terminate such agreements at any time the director determines that one or more of the conditions of the agreement have been violated.

(6) The director may deny or revoke access to workers' compensation claims records at any time the director determines such access is no longer in the public interest or is being used in a manner which violates these rules or any law of the State of Oregon or the United States.

(7) Requests to inspect or obtain copies of workers' compensation claim records must be made in writing or in person and must include:

(a) The name, address and telephone number of the requester;

(b) The reason for requesting the records;

(c) A specific identification of the public record(s) required and the format in which they are required;

(d) The number of copies required;

(e) The account number of the requester, when applicable.

(8) Except as prescribed in subsections (4)(a) through (d), a person must submit to the division an attorney retainer agreement or release signed by the claimant in order to inspect or obtain copies of workers' compensation claims records. The director may refuse to honor any release that the director determines is likely to result in disclosed records being used in a manner contrary to these rules. Upon request, the director will review proposed release forms to determine whether the proposed release is consistent with the law and this rule.

Stat. Auth.: ORS 192.502, 656.704 and 656.726(4)
Stats. Implemented: ORS 656.704 and 656.726(4)
Hist.: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0010 Reporting Requirements

(1) A subject employer must accept notice of a claim for workers' compensation benefits from an injured worker or the worker's representative. The employer must provide a copy of the "Report of Job Injury or Illness," Form 801, to the worker immediately upon request; the form must be readily available for workers to report their injuries. Proper use of this form satisfies ORS 656.265.

(2) A "Worker's and Health Care Provider's Report for Workers' Compensation Claims," Form 827, signed by the worker, is written notice of an accident, that may involve a compensable injury under ORS 656.265. The signed Form 827 shall start the claim process, but shall not relieve the worker or employer of the responsibility of filing a Form 801. If a worker reports a claim electronically the insurer may require the worker to sign a medical release form, so the insurer can obtain medical records under OAR 436-010-0240, necessary to process the claim.

(3) Employers, except self-insured employers, must report the claim to their insurers no later than five days after notice or knowledge of any claim or accident, that may result in a compensable injury. The employer's knowledge date is the earliest of the date the employer (any supervisor or manager) first knew of a claim, or of when the employer has enough facts to reasonably conclude that workers' compensation liability is a possibility. The report must provide the information requested on the Form 801, and include, but not be limited to, the worker's name, address, and Social Security number, the employer's legal name and address, and the data specified by ORS 656.262 and 656.265.

(4) For the purpose of this section, "first aid" means any treatment provided by a person who does not require a license in order to provide the service. If an injured worker requires only first aid, no notice need be given the insurer, unless the worker chooses to file a claim. If a worker signs a Form 801, the claim must be reported to the insurer. If the person must be licensed to legally provide the treatment or if a bill for the service will result, notice must be given to the insurer. When the worker requires only first aid and chooses not to file a claim, the employer must maintain records showing the name of the worker, the date, nature of the injury and first aid provided, for five years. These records shall be open to inspection by the director, or any party or its representative. If an employer subsequently learns that such an injury has resulted in medical services, disability or death, the date of that knowledge will be considered as the date on which the employer received notice or knowledge of the claim for the purposes of processing under ORS 656.262.

(5) The director may assess a civil penalty against an employer delinquent in reporting claims to its insurer in excess of ten percent of the employer's total claims during any quarter.

(6) An employer intentionally or repeatedly paying compensation in lieu of reporting to its insurer claims or accidents that may result in a compensable injury claim may be assessed a civil penalty by the director.

(7) The insurer must process and file claims and reports required by the director in compliance with ORS chapter 656, WCD administrative rules, and WCD bulletins. Such filings shall not be made by computer-printed forms, facsimile transmission (FAX), electronic data interchange (EDI), or other electronic means, unless specifically authorized by the director.

(8) When an insurer receives a claim and the insurer does not provide insurance coverage for the worker's employer on the date of injury, the insurer may check for other coverage or forward it to the director. The insurer must do one or the other within three days of determining they did not provide coverage on the date of injury. If the insurer finds that another insurer

provides coverage, the insurer must send the claim to the correct insurer within the same three day period. If the insurer cannot find coverage, the insurer must forward the claim to the director within the same three-day period.

(9) The insurer or self-insured employer and service company, if any, must be identified on all insurer generated workers' compensation forms, including insurer name, service company name (if applicable), and the mailing address and phone number of the location responsible for processing the claim.

(10) The insurer must file all disabling claims with the director within 14 days of the insurer's initial decision either to accept or deny the claim. To meet this filing requirement, the Insurer's Report, Form 1502, accompanied by the Form 801, or its electronic equivalent, is to be submitted to the director. However, when the Form 801 is not available within a time frame that would allow a timely filing, a Form 1502, accompanied by a signed Form 827 when available, will satisfy the initial reporting requirement. If the Form 801 is not submitted at the time of the initial filing of the claim, the Form 801 must be submitted within 30 days from the filing of the Form 1502. A Form 801 prepared by the insurer in place of obtaining the form from the employer/worker does not satisfy the requirement to file the Form 801, unless the employer/worker cannot be located, or the form cannot be obtained from the employer/worker due to lack of cooperation, or the form is computer-printed based upon information obtained from the employer and worker. The insurer must submit copies of all acceptance or denial notices not previously submitted to the director with the Form 1502. Form 1502 is used to report claim status and activity to the director.

(11) When submitting a Form 1502 the minimum data elements an insurer must provide are the worker's legal name, Social Security number, insurer's claim number, date of injury, and the employer's legal name.

(12) When submitting an initial compensability decision Form 1502, the insurer must report:

(a) The status of the claim;

(b) Reason for filing;

(c) Whether first payment of compensation was timely, if applicable;

(d) Whether the claim was accepted or denied timely; and

(e) Any Managed Care Organization (MCO) enrollment, and the date of enrollment, if applicable.

(13) The insurer must file an additional Form 1502 with the director within 14 days of:

(a) The date of any reopening of the claim;

(b) Changes in the acceptance or disability status;

(c) Any litigation order or insurer's decision that causes reopening of the claim or changes the acceptance or disability status;

(d) MCO enrollment that occurs after the initial Form 1502 has been filed;

(e) The insurer's knowledge that a previous Form 1502 contained erroneous information;

(f) The date of any denial; or

(g) The date the first payment of temporary disability was issued.

(14) A nondisabling claim must be reported to the director only if it is denied, in part or whole. It must be reported to the director within 14 days of the date of denial. A nondisabling claim that becomes disabling must be reported to the director within 14 days of the date of the status change.

(15) If the insurer voluntarily reopens a qualified claim under ORS 656.278, it must file a Form 3501 with the director within 14 days of the date the insurer reopens the claim.

(16) The insurer must report a new medical condition reopening on the Form 1502 if the claim cannot be closed within 14 days of the first to occur: acceptance of the new condition, or the insurer's knowledge that interim temporary disability compensation is due and payable.

(17) New condition claims that are ready to be closed within 14 days must be reported on the "Insurer Notice of Closure Summary," Form 1503, at the time the insurer closes the claim. The "Modified Notice of Acceptance" and "Updated Notice of Acceptance at Closure" letter must accompany the Form 1503.

(18) If, after receiving a claim from a worker or from someone other than the worker on the worker's behalf, the insurer receives written communication from the worker stating the worker never intended to file a claim and wants the claim "withdrawn," the insurer must submit a Form 1502 with a copy of the worker's communication to the director, if the claim had previously been reported.

(19) The director may issue a civil penalty against any insurer delinquent in reporting or in submitting Forms 801, 1502, 1503 or 1644 with a late or error ratio in excess of twenty percent during any quarter. For the purposes of this section, a claim or form shall be deemed to have been reported or submitted timely according to the provisions of ORS 656.726(4).

(20) Insurers must make an annual report to the director reporting attorney fees, attorney salaries, and all other costs of legal services paid under ORS chapter 656. The report must be submitted on forms furnished by the director for that purpose. Reports for each calendar year must be filed not later than March 1 of the following year.

(21) If an insurer elects to process and pay supplemental disability benefits, under ORS 656.210(5)(a), the insurer does not need to inform the director of their election. The insurer must request reimbursement, under OAR 436-060-0500, by filing Form 3504 "Supplemental Disability Benefits Quarterly Reimbursement Request" with the director for any quarter during which they processed and paid supplemental disability benefits. If an insurer elects not to process and pay supplemental disability benefits, the insurer must submit Form 3530, "Supplemental Disability Election Notification," to the director. The election remains in effect for all supplemental disability claims the insurer receives until the insurer changes

its election. The election is made by the insurer and applies to all service companies an insurer may use for processing claims.

(22) An insurer may change its election made under section (21):

(a) Annually and

(b) Once after the division completes its first audit of supplemental disability payments made by the insurer.

Stat. Auth.: ORS 656.262, 656.264, 656.265(6), 656.704, 656.726(4) and 656.745
Stats. Implemented: ORS 656.210, 656.262, 656.264, 656.265, 656.704, and 656.726(4)
Hist.: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0012 Notices and Correspondence Following the Death of a Worker

(1) If a worker is deceased, regardless of the cause of death, an insurer must:

(a) Address all future notices and correspondence to the worker's estate or qualified beneficiaries;

(b) Provide a written notice of acceptance or denial of a claim to the estate of the worker; and

(c) Issue a Notice of Closure, when applicable, to the estate of the worker. The insurer must mail the worker's copy of the Notice of Closure to the worker's last known address. The insurer may mail copies of the Notice of Closure to any known or potential beneficiaries.

(2) Other notices required under this chapter intended for the worker are not required when the worker is deceased.

Stat. Auth: ORS 656.726(4)
Stat. Impltd: ORS 656.262, 656.264, 656.268
Hist.: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0015 Required Notice And Information

(1) When an injured worker's attorney has given written notice of representation, prior or simultaneous written notice must be given to the worker's attorney under ORS 656.331 when:

(a) The director or insurer requests the worker to submit to a medical examination;

(b) The insurer contacts the worker regarding any matter which may result in denial, reduction or termination of the worker's benefits; or

(c) The insurer contacts the worker regarding any matter relating to disposition of a claim under ORS 656.236.

(2) The director shall assess a civil penalty against an insurer who intentionally or repeatedly fails to give notice as required under section (1) of this rule.

(3) The insurer or the service company must provide the pamphlet, "What Happens if I'm Hurt on the Job?," Form 1138, to every injured worker who has a disabling claim with the first time-loss check or earliest written correspondence. For nondisabling claims, the information page, "A Guide for Workers Hurt on the Job," Form 3283, may be provided in lieu of Form 1138, unless the worker specifically requests Form 1138.

(4) The insurer must provide Form 3283 to their insured employers. The employer must provide the Form 3283 to the worker at the time a worker files a claim for workers' compensation benefits. The Form 3283 may be printed on the back of the Form 801.

(5) The insurer must provide the "Notice to Worker," Form 3058, or its equivalent to the worker with the initial notice of acceptance on the claim under OAR 436-060-0140(7). For the purpose of this rule, an equivalent to the Form 3058 must include all of the statutory and rule requirements.

(6) Additional notices the insurer must send to a worker are contained in OAR 436-060-0018, 436-060-0030, 436-060-0035, 436-060-0095, 436-060-0105, 436-060-0135, 436-060-0140, and 436-060-0180.

(7) When an insurer changes claims processing locations, service companies, or self-administration, the insurer must provide at least 10 days prior notice to workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, and mailing address of the new claim processor.

(8) The insurer must provide the worker an explanation of any change in the wage used that differs from what was initially reported in writing to the insurer. Prior to claim closure on a disabling claim, the insurer must send the worker a notice documenting the wage upon which benefits were based. Work disability, if applicable, will be determined when the claim is closed. The notice must also explain how the worker can appeal the insurer's wage calculation if the worker disagrees with the wage.

Stat. Auth.: ORS 656.331, 656.704, 656.726(4), and 656.745
Stats. Implemented: ORS 656.331, 656.704, and 656.726(4)
Hist.: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0017 Release of Claim Documents

(1) For the purpose of this rule:

(a) "Documents" include, but are not limited to, medical records, vocational records, written and automated payment ledgers for both time loss and medical services, payroll records, recorded statements, insurer generated records (insurer generated records exclude a claim examiner's generated file notes, such as documentation or justification concerning setting or adjusting reserves, claims management strategy, or any privileged communications), all forms required to be filed with the director, notices of closure, electronic transmissions, and correspondence between the insurer, service providers, claimant, the division or the Workers' Compensation Board.

(b) "Possession" means documents making up, or relating to, the insurer's claim record on the date of mailing the documents to the claimant, claimant's attorney or claimant's beneficiary. Any documents that have been received by the insurer five or more working days prior to the date of mailing shall be considered as part of the insurer's claim record even though the documents may not have yet reached the insurer's claim file.

(2) The insurer must date stamp each document upon receipt with the date it is received. The date stamp must include the month, day, year of receipt, and name of the company, unless the document already contains the date information and name of recipient company, as in faxes, e-mail and other electronically transmitted communications.

(3) A request for copies of claim documents must be submitted to the insurer, self-insured employer, or their respective service company, and copied simultaneously to defense counsel, if known.

(4) The insurer must furnish, without cost, legible copies of documents in its possession relating to a claim, upon request of the claimant, claimant's attorney or claimant's beneficiary, at times other than those provided for under ORS 656.268 and OAR chapter 438, as provided in this rule. Except as provided in OAR 436-060-0180, an initial request by anyone other than the claimant or claimant's beneficiary must be accompanied by a worker signed attorney retention agreement or a medical release signed by the worker. The signed medical release must be in a form or format as the director may provide by bulletin. Information not otherwise available through this release, but relevant to the claim, may only be obtained in compliance with applicable state or federal laws. Upon the request of the claimant's attorney, a request for documents shall be considered an ongoing request for future documents received and generated by the insurer for 180 days after the initial mailing date under section (7) or until a hearing is requested before the Workers' Compensation Board. The insurer must provide such new documents to claimant's attorney every 30 days, unless specific documents are requested sooner by the attorney. Such documents must be provided within the time frame of section (7).

(5) Once a hearing is requested before the Workers' Compensation Board, the release of documents is controlled by OAR chapter 438. This rule applies subsequently if the hearing request is withdrawn or when the hearing record is closed, provided a request for documents is renewed.

(6) Upon request, the entire health information record in the possession of the insurer will be provided to the worker or the worker's representative. This includes records from all healthcare providers, except that the following may be withheld:

(a) Information that was obtained from someone other than a healthcare provider under a promise of confidentiality and access to the information would likely reveal the source of the information,

(b) Psychotherapy notes,

(c) Information compiled for use in a civil, criminal, or administration action or proceeding; and

(d) Other reasons specified by federal regulation.

(7) The insurer must furnish copies of documents within the following time frames:

(a) The documents of open and closed files, or microfilmed files must be mailed within 14 days of receipt of a request, and copies of documents of archived files within 30 days of receipt of a request.

(b) If a claim is lost or has been destroyed, the insurer must so notify the requester in writing within 14 days of receiving the request for claim documents. The insurer must reconstruct and mail the file within 30 days from the date of the lost or destroyed file notice.

(c) If no documents are in the insurer's possession at the time the request is received, the 14 days within which to provide copies of documents starts when the insurer does receive some documentation on the claim if that occurs within 90 days of receipt of the request.

(d) Documents are deemed mailed when addressed to the last known address of the claimant, claimant's beneficiary, or claimant's attorney and deposited in the U.S. Mail.

(8) The documents must be mailed directly to the claimant's or beneficiary's attorney, when the claimant or beneficiary is represented. If the documents have been requested by the claimant or beneficiary, the insurer must inform the claimant or beneficiary of the mailing of the documents to the attorney. The insurer is not required to furnish copies to both the claimant or beneficiary and the attorney. However, if a claimant or beneficiary changes attorneys, the insurer must furnish the new attorney copies upon request.

(9) The director may assess a civil penalty against an insurer who fails to furnish documents as required under this rule. The matrix attached to these rules in Appendix "A" will be used in assessing penalties.

(10) Rule violation complaints about release of requested claims documents must be in writing, mailed or delivered to the division within 180 days of the request for documents, and must include a copy of the request submitted under section (3). When notified by the director that a complaint has been filed, the insurer must respond in writing to the division. The response must be mailed or delivered to the director within 14 days of the mailing date of the division's inquiry letter. A copy of the response, including any attachments, must be sent simultaneously to the requester of claim documents. If the division does not receive a timely response or the insurer provides an inadequate response (e.g. failing to answer specific questions or provide requested documents), a civil penalty may be assessed under OAR 436-060-0200 against the insurer. Assessment of a penalty does not relieve the insurer of the obligation to provide a response.

Stat. Auth.: ORS 656.360, 656.362, 656.704, 656.726(4), and 656.745
Stats. Implemented: ORS 656.704 and 656.726(4)
Hist.: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0018 Nondisabling/Disabling Reclassification

(1) When the insurer changes the classification of an accepted claim, the insurer must submit an "Insurer's Report," Form 440-1502, indicating a change in status, to the director within 14 days from the date of the new classification. A notice of change of classification must be communicated by issuing a Modified Notice of Acceptance. This notice must include an explanation of the change in status and must be sent to the

director, the worker, and the worker's attorney if the worker is represented. If the claim qualifies for closure, the insurer must close the claim under ORS 656.268(5).

(2) The insurer must reclassify a nondisabling claim to disabling within 14 days of receiving information that any condition already accepted meets the disabling criteria in this rule. A claim is disabling if any of the following criteria apply:

(a) Temporary disability is due and payable; or

(b) The worker is medically stationary within one year of the date of injury and the worker will be entitled to an award of permanent disability; or

(c) The worker is not medically stationary, but there is a reasonable expectation that the worker will be entitled to an award of permanent disability when the worker does become medically stationary.

(3) Under ORS 656.262 (6)(b)(F) and (7)(a) the insurer must issue a Modified Notice of Acceptance and change the classification from nondisabling to disabling upon acceptance of a new or omitted condition that meets the disabling criteria in this rule.

(4) If a claim has been classified as nondisabling for one year or less after the date of acceptance and the worker believes the claim was or has become disabling, the worker may request reclassification by submitting a written request for review of the classification status to the insurer under ORS 656.277.

(5) Within 14 days of the worker's request, the insurer must review the claim and,

(a) If the classification is changed to disabling, provide notice under this rule; or

(b) If the insurer believes evidence supports denying the worker's request to reclassify the claim, the insurer must send a Notice of Refusal to Reclassify to the worker and the worker's attorney, if the worker is represented. The notice must include the following statement, in bold print:

"If you disagree with this Notice of Refusal to Reclassify, you must appeal by contacting the Workers' Compensation Division within sixty (60) days of the mailing of this notice or you will lose your right to appeal. The address and telephone number of the Workers' Compensation Division are: [INSURER: Insert current address and telephone number of the Workers' Compensation Division, Appellate Review Unit, here.]."

(6) A worker dissatisfied with the decision in the Notice of Refusal to Reclassify may appeal to the director. Such appeal must be made no later than the 60th day after the Notice is mailed. The appeal must include a copy of the insurer's Notice of Refusal to Reclassify.

(7) For claims that are reclassified from nondisabling to disabling within one year from the date of acceptance, the aggravation rights begin with the first valid closure of the claim.

(8) For claims that are not reclassified from nondisabling to disabling within one year from the date of acceptance, the aggravation rights continue to run from the date of injury.

(9) When a claim has been classified as nondisabling for at least one year after the date of acceptance, a worker who believes the claim was or has become disabling may submit a claim for aggravation according to the provisions of ORS 656.273.

(10) Failure of the insurer or self-insured employer to respond timely to a request for reclassification may result in the assessment of penalties under OAR 436-060-0200 or attorney fees under ORS 656.386(3).

(11) Notwithstanding (12), once a claim has been accepted and classified as disabling for more than one year from date of acceptance, all aspects of the claim are classified as disabling and remain disabling. Any additional conditions or aggravations subsequently accepted must be processed according to provisions governing disabling claims, including closure under ORS 656.268.

(12) If a claim has been classified as disabling and the insurer determines the criteria for a disabling claim were never satisfied, the insurer may reclassify the claim to nondisabling. The insurer must notify the worker and the worker's representative, if applicable, by issuing a Modified Notice of Acceptance.

(a) The Modified Notice of Acceptance must advise the worker that he or she has 60 days from the date of the notice to appeal the decision.

(b) Appeals of such reclassification decisions are made to the Appellate Review Unit for issuance of a Director's Review order.

(13) The worker's appeal must be in writing. The worker may use the form specified by the director for requesting review of the insurer's claim classification decision.

(14) The worker's appeal under section (6) or (12) must be copied to the insurer.

(15) A worker need not be represented by an attorney to appeal the insurer's classification decision.

(16) The director will acknowledge receipt of the request in writing to the injured worker, the worker's attorney, if any, and the insurer, and initiate the review.

(17) Within 14 days of the director's acknowledgement, the insurer must provide the director and all other parties with the complete medical record and all official actions and notices on the claim. The director may impose penalties against an insurer under OAR 436-060-0200 if the insurer fails to provide claim documents in a timely manner.

(18) Within the same 14 days, the worker may submit any additional evidence for the director to consider. Copies must be provided to all other parties at the same time.

(19) After receiving and reviewing the required documents, the director will issue a Director's Review order.

(20) The worker and the insurer have 30 days from the mailing date of the Director's Review order to appeal the director's decision to the Hearings Division of the Workers' Compensation Board.

(21) The director may reconsider, abate, or withdraw any Director's Review order before the order becomes final by operation of law.

Stat. Auth.: ORS 656.268, ORS 656.726
Stats. Implemented: ORS 656.210, ORS 656.212, ORS 656.214, ORS 656.262, ORS 656.268, ORS 656. 273, ORS 656.277, ORS 656.745, and ORS 656.726
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0019 Determining and Paying the Three Day Waiting Period

(1) Under ORS 656.210 and 656.212, the three day waiting period is three consecutive calendar days beginning with the first day the worker loses time or wages from work as a result of the compensable injury, subject to the following:

(a) If the worker leaves work but returns and completes the work shift without loss of wages, that day shall not be considered the first day of the three day waiting period.

(b) If the worker leaves work but returns and completes the work shift and receives reduced wages, that day shall be considered the first day of the three day waiting period.

(c) If the worker does not complete the work shift, that day shall be considered the first day of the three day waiting period even if there is no loss of wages. For the purpose of this rule, an attending physician's or authorized nurse practitioner's authorization of temporary disability is not required to begin the waiting period; however, the waiting period would not be due and payable unless authorized.

(2) Under ORS 656.210(3), no disability payment is due the worker for temporary total disability suffered during the first three calendar days after the worker leaves work as a result of a compensable injury, unless the worker is totally disabled after the injury and the total disability continues for a period of 14 consecutive days or unless the worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability. For the purpose of this rule, admittance as an inpatient to a hospital can be any time following the date of the injury, but must be within 14 days of the first onset of total disability to waive the three day waiting period.

(3) If compensation is due and payable for the three day waiting period, the worker must be paid for one-half day for the initial work day lost if the worker leaves the job during the first half of the shift and does not return to complete the shift. No compensation is due for the initial day of the waiting period if the worker leaves the job during the second half of the shift.

(4) If a worker is employed with varying days off or cyclic work schedules, the three day waiting period shall be determined using the work schedule of the week the worker begins losing time or wages as a result of the injury. If the worker is no longer employed with the employer at injury or does not have an established schedule when the worker begins losing time/wages, the three day waiting period and scheduled days off shall be based on the work schedule of the week the worker was injured.

Stat. Auth.: ORS 656.210, 656.212, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.210, 656.212
Hist.: Amended 10/26/04 as WCD Admin. Order 04-064, eff. 1/1/05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0020 Payment of Temporary Total Disability Compensation

(1) An employer may pay compensation under ORS 656.262(4) with the approval of the insurer under ORS 656.262(13). Making such payments does not constitute a waiver or transfer of the insurer's duty to determine the worker's entitlement to benefits, or responsibility for the claim to ensure timely benefit payments. The employer must provide adequate payment documentation as the insurer may require to meet its responsibilities.

(2) Under ORS 656.005(30), no temporary disability is due and payable for any period of time in which the person has withdrawn from the workforce. For the purpose of this rule, a person who has withdrawn from the workforce, includes, but is not limited to:

(a) A person who, prior to reopening under ORS 656.267, 656.273 or 656.278, was not working and had not made reasonable efforts to obtain employment, unless such efforts would be futile as a result of the compensable injury.

(b) A person who was a full time student for at least six months in the 52 weeks prior to injury elects to return to school full time, unless the person can establish a prior customary pattern of working while attending school. For purposes of this subsection, "full time" is defined as twelve or more quarter hours or the equivalent.

(3) No temporary disability is due and payable for any period of time where the insurer has requested from the worker's attending physician or authorized nurse practitioner verification of the worker's inability to work and the physician or authorized nurse practitioner cannot verify it under ORS 656.262(4)(d), unless the worker has been unable to receive treatment for reasons beyond the worker's control. Before withholding temporary disability under this section, the insurer must inquire of the worker whether a reason beyond the worker's control prevented the worker from receiving treatment. If no valid reason is found or the worker refuses to respond or cannot be located, the insurer must document its file regarding those findings. The insurer must provide the division a copy of the documentation within 20 days, if requested. If the attending physician or authorized nurse practitioner is unable to verify the worker's inability to work, the insurer may stop temporary disability payments and, in place of the scheduled payment, must send the worker an explanation for stopping the temporary disability payments. When verification of temporary disability is received from the attending physician or authorized nurse practitioner, the insurer must pay temporary disability within 14 days of receiving the verification of any authorized period of time loss, unless otherwise denied.

(4) Authorization from the attending physician or authorized nurse practitioner may be oral or written. The insurer at claim closure, or the division at reconsideration of the claim closure, may infer authorization from such medical records as a surgery report or hospitalization record that reasonably reflects an

inability to work because of the compensable claim, or from a medical report or chart note generated at the time of, and indicating, the worker's inability to work. No compensation is due and payable after the worker's attending physician or authorized nurse practitioner ceases to authorize temporary disability or for any period of time not authorized by the attending physician or authorized nurse practitioner under ORS 656.262(4)(g).

(5) An insurer may suspend temporary disability benefits without authorization from the division under ORS 656.262(4)(e) when all of the following circumstances apply:

(a) The worker has missed a regularly scheduled appointment with the attending physician or authorized nurse practitioner.

(b) The insurer has sent a certified letter to the worker and a letter to the worker's attorney, at least ten days in advance of a rescheduled appointment, stating that the appointment has been rescheduled with the worker's attending physician or authorized nurse practitioner; stating the time and date of the appointment; and giving the following notice, in prominent or bold face type:

"You must attend this appointment. If there is any reason you cannot attend, you must tell us before the date of the appointment. If you do not attend, your temporary disability benefits will be suspended without further notice, as provided by ORS 656.262(4)(e)."

(c) The insurer verifies that the worker has missed the rescheduled appointment.

(d) The insurer sends a letter to the worker, the worker's attorney and the division giving the date of the regularly scheduled appointment that was missed, the date of the rescheduled appointment that was missed, the date of the letter being the day benefits are suspended, and the following notice, in prominent or bold face type:

"Since you missed a regular appointment with your doctor, we arranged a new appointment. We notified you of the new appointment by certified mail and warned you that your benefits would be suspended if you failed to attend. Since you failed to attend the new appointment, your temporary disability benefits have been suspended. In order to resume your benefits, you must schedule and attend an appointment with your doctor who must verify your continued inability to work."

(6) If temporary disability benefits end because the insurer or employer:

(a) Speaks by telephone with the attending physician or authorized nurse practitioner, or the attending physician's or authorized nurse practitioner's office, and negotiates a verbal release of the worker to return to any type of work as a result, when no return to work was previously authorized; and

(b) The worker has not already been informed of the release by the attending physician or authorized nurse practitioner or returned to work; then

(c) The insurer must:

(A) Document the facts;

(B) Communicate the release to the worker by mail within 7 days. The communication to the worker of the negotiated return to work release may be contained in an offer of modified employment; and

(C) Advise the worker of their reinstatement rights under ORS chapter 659A.

(7) When concurrent temporary disability is due the worker as a result of two or more accepted claims, the insurers may petition the division to make a pro rata distribution of compensation due under ORS 656.210 and 656.212. The insurer must provide a copy of the request to the worker, and the worker's attorney if represented. The division's pro rata order shall not apply to any periods of interim compensation payable under ORS 656.262 and also does not apply to benefits under ORS 656.214 and 656.245. Claims subject to the pro rata order approved by the division must be closed under OAR 436-030 and ORS 656.268, when appropriate. The insurers shall not unilaterally prorate temporary disability without the approval of the division, except as provided in section (8) of this rule. The division may order one of the insurers to pay the entire amount of temporary disability due or make a pro rata distribution between two or more of the insurers. The pro rata distribution ordered by the division shall be effective only for benefits due as of the date all claims involved are in an accepted status. The order pro rating compensation will not apply to periods where any claim involved is in a deferred status.

(8) When concurrent temporary disability is due the worker as a result of two or more accepted claims involving the same worker, the same employer and the same insurer, the insurer may make a pro rata distribution of compensation due under ORS 656.210 and 656.212 without an order by the division. The worker must receive compensation at the highest temporary disability rate of the claims involved.

(9) If a closure under ORS 656.268 has been found to be premature and there was an open ended authorization of temporary disability at the time of closure, the insurer must begin payments under ORS 656.262, including retroactive periods, and pay temporary disability for as long as authorization exists or until there are other lawful bases to terminate temporary disability.

(10) If a denied claim has been determined to be compensable, the insurer must begin temporary disability payments under ORS 656.262, including retroactive periods, if the time loss authorization was open ended at the time of denial, and there are no other lawful bases to terminate temporary disability.

Stat. Auth.: ORS 656.210(2), 656.245, 656.262, 656.307(1)(c), 656.704, and 656.726(4)
Stats. Implemented: ORS 656.210, 656.212, 656.262 (Oregon Laws 2009, ch. 526), 656.307, 656.704, 656.726(4)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0025 Rate Of Temporary Disability Compensation

(1) The rate of compensation shall be based on the wage of the worker at the time of injury, except in the case of an

occupational disease, for which the rate of compensation will be based on the wage as outlined in ORS 656.210(2)(d)(B). Employers shall not continue to pay wages in lieu of statutory temporary total disability payments due. However, under ORS 656.018(6) the employer is not precluded from supplementing the amount of temporary total disability paid the worker. Employers must separately identify workers' compensation benefits from other payments and shall not have payroll deductions withheld from such benefits.

(2) Notwithstanding section (1), under ORS 656.262(4)(b), a self-insured employer may continue the same wage with normal deductions withheld (e.g. taxes, medical, and other voluntary deductions) at the same pay interval that the worker received at the time of injury. If the pay interval or amount of wage changes (excluding wage increases), the worker must be paid temporary disability as otherwise prescribed by the workers' compensation law. The claim shall be classified as disabling. The rate of temporary total disability that would have otherwise been paid had continued wages not occurred and the period of disability will be reported to the division.

(3) The rate of compensation for regularly employed workers shall be computed as outlined in ORS 656.210 and this rule. "Regularly employed" means actual employment or availability for such employment.

(a) Monthly wages shall be divided by 4.35 to determine weekly wages. Seasonal workers paid monthly must have their weekly wages determined under OAR 436-060-0025(5).

(b) For workers employed through union hall call board insurers must compute the rate of compensation on the basis of a five-day work week at 40 hours a week, regardless of the number of days actually worked per week.

(4) The insurer shall resolve wage disputes by contacting the employer to confirm the correct wage and then contacting the worker with that information. If the worker does not agree with the wage calculated by the insurer, the worker may request a hearing with the Hearings Division of the Workers' Compensation Board.

(5) The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule.

(a) For workers employed seasonally, on call, paid hourly, paid by piece work or with varying hours, shifts or wages:

(A) Insurers must use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers with multiple employers at the time of injury who qualify under ORS 656.210(2)(b) and OAR 436-060-0035, insurers shall average all earnings for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist, insurers must use the actual weeks of employment (excluding any extended gaps) with the employer at injury or all earnings, if the worker qualifies under ORS 656.210(2)(b) and OAR 436-060-0035, up to the previous 52 weeks. For the purpose of this rule, gaps shall not be added together and must be considered on a claim-by-claim basis; the determination of whether a gap is extended must be made in light of its length and of the circumstances of the individual employment relationship itself, including whether the parties contemplated that such gaps would occur when they formed the relationship. For workers employed less than four weeks, insurers shall use the intent of the wage earning agreement as confirmed by the employer and the worker. For the purpose of this section, the wage earning agreement may be either oral or in writing.

(B)(i) Where there has been a change in the wage earning agreement due only to a pay increase or decrease during the 52 weeks prior to the date of injury, insurers must use the worker's average weekly hours worked for the 52 week period, or lesser period as required in (5)(a)(A) of this section, multiplied by the wage at injury to determine the worker's current average weekly earnings.

(ii) Where there has been a change in the wage earning agreement due to a change of hours worked, change of job duties, or for other reasons either with or without a pay increase or decrease, during the 52 weeks prior to the date of injury, insurers must average earnings for the weeks worked under the most recent wage earning agreement, calculated by the method described in (5)(a)(A).

(iii) For workers employed less than four weeks under a changed wage earning agreement as described in this subsection, insurers must use the intent of the most recent wage earning agreement as confirmed by the employer and the worker.

(iv) For determining benefits under this rule for occupational disease claims, in place of "the date of injury," insurers must use the wage at the date of disability if the worker was working at the time of medical verification of the inability to work. If the worker was not working due to the injury at the time of medical verification of the inability to work insurers must use the wage at the date of last regular employment.

(b) For workers employed through a temporary service provider on a "temporary basis," or a worker-leasing company as defined in OAR 436-050, insurers will determine the weekly wage by the method provided in subsection (a) of this section. However, each job assignment shall not be considered a new wage earning agreement.

(c) For workers paid salary plus considerations (e.g. rent, utilities, food, etc.) insurers must compute the rate on salary only if the considerations continue during the period the worker is disabled due to the injury. If the considerations do not continue, the insurer must use salary plus a reasonable value of those considerations. Expenses incurred due to the job and reimbursed by the employer (e.g. meals, lodging, per diem, equipment rental) are not considered part of the wage.

(d) Earnings from a second job will be considered for calculating temporary partial disability only to the extent that the post-injury income from the second job exceeds the pre-injury income from the second job (i.e., increased hours or increased wage).

(e) For workers employed where tips are a part of the worker's earnings insurers must use the wages actually paid, plus the amount of tips required to be reported by the employer under section 6053 of the Internal Revenue Code of 1954, as amended, or the amount of actual tips reported by the worker, whichever amount is greater.

(f) Insurers shall consider overtime hours only when the worker worked overtime on a regular basis. Overtime earnings must be included in the computation at the overtime rate. For example, if the worker worked one day of overtime per month, use 40 hours at regular wage and two hours at the overtime wage to compute the weekly rate. If overtime varies in hours worked per day or week, use the averaging method described in subsection (a). One-half day or more will be considered a full day when determining the number of days worked per week.

(g) Bonus pay shall be considered only when provided as part of the written or verbal employment contract as a means to increase the worker's wages. End-of-the-year and other one time bonuses paid at the employer's discretion shall not be included in the calculation of compensation.

(h) Incentive pay shall be considered only when regularly earned. If incentive pay earnings vary, use the averaging method described in subsection (a).

(i) Covered workers with no wage earnings such as volunteers, jail inmates, etc., must have their benefits computed on the same assumed wage as that upon which the employer's premium is based.

(j) For workers paid by commission only or commission plus wages insurers must use the worker's average commission earnings for previous 52 weeks, if available. For workers without 52 weeks of earnings, insurers must use the assumed wage on which premium is based. Any regular wage in addition to commission must be included in the wage from which compensation is computed.

(k) For workers who are sole proprietors, partners, officers of corporations, or limited liability company members including managers, insurers must use the assumed wage on which the employer's premium is based.

(l) For school teachers or workers paid in a like manner, insurers must use the worker's annual salary divided by 52 weeks to arrive at weekly wage. Temporary disability benefits shall extend over the calendar year.

(m) For workers with cyclic schedules, insurers must average the hours of the entire cycle to determine the weekly wage. For purposes of temporary disability payments, the cycle shall be considered to have no scheduled days off. For example: A worker who works ten hours for seven days, has seven scheduled days off, then repeats the cycle, is considered to have a 14 day cycle. The weekly wage and payment schedule would be based on 35 hours a week with no scheduled days off.

(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.

Stat. Auth.: ORS 656.210(2), 656.704, and 656.726(4)
Stats. Implemented: ORS 656.210, 656.704, 656.726(4)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0030 Payment of Temporary Partial Disability Compensation

(1) The amount of temporary partial disability compensation due a worker shall be determined by:

(a) Subtracting post-injury wage earnings by the worker from any kind of work from

(b) The wage used to compute the rate of compensation at the time of injury; then

(c) Dividing the difference by the wage earnings used in subsection (b) to arrive at the percentage of loss of wages; then

(d) Multiplying the current temporary total disability compensation rate by the percentage of loss of wages in subsection (c).

(2) Notwithstanding section (1), for workers whose rate of compensation is based on an assumed wage, "post-injury wage earnings" will be that proportion of the assumed wage which the hours worked during the period of temporary partial disability represent as a percentage of the hours worked prior to the injury.

(3) An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (1) from the date an injured worker begins wage earning employment, prior to claim closure, unless the worker refuses modified work under ORS 656.268(4)(c)(A) through (F). If the worker is with a new employer and upon request of the insurer to provide wage information, it shall be the worker's responsibility to provide documented evidence of the amount of any wages being earned. Failure to do so shall be cause for the insurer to assume that post-injury wages are the same as or higher than the worker's wages at time of injury.

(4) For the purpose of section (5) of this rule:

(a) "Commute" means the lesser of the distance traveled from the worker's residence at the time of injury to the work site or the worker's residence at the time of the modified work offer to the work site;

(b) "Where the worker was injured" means the location where the worker customarily reported or worked at the time of injury; and

(c) "Temporary employees" has the same meaning as defined in OAR 436-050-0420.

(5) Under ORS 656.325(5)(a), an insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (1) as if the worker had begun the employment when an injured worker fails to begin wage earning employment, under the following conditions:

(a) The employer or insurer:

(A) Notifies the attending physician or authorized nurse practitioner of the physical tasks to be performed by the injured worker;

(B) Notifies the attending physician or authorized nurse practitioner of the location of the modified work offer; and

(C) Asks the attending physician or authorized nurse practitioner if the worker can, as a result of the compensable injury, physically commute to and perform the job.

(b) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker's capabilities and the commute is within the physical capacity of the worker; and

(c) The employer or insurer has confirmed the offer of employment in writing to the worker stating:

(A) The beginning time, date and place;

(B) The duration of the job, if known;

(C) The wages;

(D) An accurate description of the physical requirements of the job;

(E) That the attending physician or authorized nurse practitioner has found the job to be within the worker's capabilities and the commute within the worker's physical capacity;

(F) The worker's right to refuse the offer of employment without termination of temporary total disability if any of the following conditions apply:

(i) The offer is at a site more than 50 miles from where the worker was injured, unless the work site is less than 50 miles from the worker's residence, or the intent of the employer and worker at the time of hire or as established by the employment pattern prior to the injury was that the job involved multiple or mobile work sites and the worker could be assigned to any such site. Examples of such sites include, but are not limited to logging, trucking, construction workers, and temporary employees;

(ii) The offer is not with the employer at injury;

(iii) The offer is not at a work site of the employer at injury;

(iv) The offer is not consistent with existing written shift change policy or common practice of the employer at injury or aggravation; or

(v) The offer is not consistent with an existing shift change provision of an applicable union contract; and

(G) The following notice, in prominent or bold face type:

"If you refuse this offer of work for any of the reasons listed in this notice, you should write to the insurer or employer and tell them your reason(s) for refusing the job. If the insurer reduces or stops your temporary total disability and you disagree with that action, you have the right to request a hearing. To request a hearing you must send a letter objecting to the insurer's action(s) to the Worker's Compensation Board, 2601 25th Street SE, Suite 150, Salem, Oregon 97302-1282."

(6) Under ORS 656.325(5)(b), the insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (1) as if the worker had begun the employment when the attending physician or authorized nurse practitioner approves employment in a modified job that would have been offered to the worker if the worker had not been terminated from employment for violation of work rules or other disciplinary reasons, under the following conditions:

(a) The employer has a written policy of offering modified work to injured workers;

(b) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (1);

(c) The attending physician or authorized nurse practitioner has been notified by the employer or insurer of the physical tasks to be performed by the injured worker; and

(d) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker's capabilities.

(7) Under ORS 656.325(5)(c), the insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (1) as if the worker had begun the employment when the attending physician or authorized nurse practitioner approves employment in a modified job whether or not such a job is available if the worker is a person present in the United States in violation of federal immigration laws, under the following conditions:

(a) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (1);

(b) The attending physician or authorized nurse practitioner has been notified by the employer or insurer of the physical tasks that would have been performed by the injured worker; and

(c) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker's capabilities.

(8) Temporary partial disability must be paid at the full temporary total disability rate as of the date a modified job no longer exists or the job offer is withdrawn by the employer. This includes, but is not limited to, termination of temporary employment, layoff or plant closure. A worker who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim shall be included in this section. For the purpose of this rule, when a worker who has been doing modified work quits the job or the employer terminates the worker for violation of work rules or other disciplinary reasons it is not a withdrawal of a job offer by the

employer, but shall be considered the same as the worker refusing wage earning employment under ORS 656.325(5)(a). This section does not apply to those situations described in sections (5), (6), and (7) of this rule.

(9) When the worker's disability is partial only and temporary in character, temporary partial disability compensation under ORS 656.212 shall continue until:

(a) The attending physician or authorized nurse practitioner verifies that the worker can no longer perform the modified job and is again temporarily totally disabled;

(b) The compensation is terminated by order of the division or by claim closure by the insurer under ORS 656.268; or

(c) The compensation is lawfully suspended, withheld or terminated for any other reason.

(10) In determining failure on the part of the worker in section (5) and for purposes of subsection (1)(a), "post-injury wages" are the wages the worker could have earned by accepting a job offer, or actual wages earned, whichever is greater, and any unemployment, sick or vacation leave payments received.

(11) If temporary disability benefits end because the insurer or employer:

(a) Speaks by telephone with the attending physician or authorized nurse practitioner, or the attending physician's or authorized nurse practitioner's office, and negotiates a verbal release of the worker to return to any type of work as a result, when no return to work was previously authorized; and

(b) The worker has not already been informed of the release by the attending physician or authorized nurse practitioner or returned to work; then

(c) The insurer must:

(A) Document the facts;

(B) Communicate the release to the worker by mail within 7 days; the communication to the worker of the negotiated return to work release may be contained in an offer of modified employment; and

(C) Advise the worker of their reinstatement rights under ORS chapter 659A.

(12) The insurer must provide the injured worker and the worker's attorney a written notice of the reasons for changes in the compensation rate, and the method of computation, whenever a change is made.

Stat. Auth.: ORS 656.212, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.212, 656.325(5), 656.704, 656.726(4), and section 12 (4)(c), chapter 865, Oregon Laws 2001
Hist.: Amended 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0035 Supplemental Disability for Workers with Multiple Jobs at the Time of Injury

(1) For the purpose of this rule:

(a) "Assigned processing administrator" is the company or business that the director has selected and authorized to process and pay supplemental disability benefits on behalf of the director, when the insurer has elected not to process and pay these benefits.

(b) "Primary job" means the job at which the injury occurred.

(c) "Secondary job" means any other job(s) held by the worker in Oregon subject employment at the time of injury.

(d) "Temporary disability" means wage loss replacement for the primary job.

(e) "Supplemental disability" means wage loss replacement for the secondary job(s) that exceeds the temporary disability, up to, but not exceeding, the maximum established by ORS 656.210.

(f) "Verifiable documentation" means information that provides:

(A) Identification of the Oregon subject employer(s) and the time period that establishes the worker held the secondary job, in addition to the primary job, at the time of injury; and

(B) Adequate information to calculate the average weekly wage in accordance with OAR 436-060-0025.

(g) "Insurer" includes service company.

(2) The insurer shall establish the temporary disability rate by multiplying the weekly wage, determined under OAR 436-060-0025, from the primary employer by 66 2/3% (.6667). If the result meets or exceeds the maximum temporary disability rate, the worker is not eligible for supplemental disability benefits.

(3) Within five business days of receiving notice or knowledge of employment in addition to the primary job on a claim on which the temporary disability rate for the primary job does not meet or exceed the maximum rate, the insurer must:

(a) Send the worker an initial notice informing the worker what type of information the insurer or the assigned processing administrator must receive to determine the worker's eligibility for supplemental disability.

(b) Clearly advise the worker, in the initial notice, that the insurer must receive verifiable documentation within 60 days of the mailing date of the notice or the worker shall be found ineligible for supplemental disability.

(c) Copy the assigned processing administrator, if the insurer has elected not to process and pay supplemental disability benefits. The notice must contain the name, address, and telephone number of the assigned processing administrator, and must clearly advise the worker that the verifiable documentation must be sent to the assigned processing administrator.

(4) The initial notice in section (3) must inform the worker that if the verifiable documentation is not received, the insurer will determine the worker's temporary disability rate based only on the job at which the injury occurred. Any delay in the payment of a higher disability rate because of the worker's failure to provide verifiable documentation under this paragraph will not result in a penalty under ORS 656.262(11).

(5) Within 14 days of receiving the worker's verifiable documentation, the insurer or the assigned processing administrator must determine the worker's eligibility for supplemental disability and must communicate the decision to the worker and the worker's representative, if any, in writing. The letter must also advise the worker why he/she is not eligible when that is the decision and how to appeal the decision, if the worker disagrees with the decision.

(6) A worker is eligible if:

(a) The worker was employed at the secondary job by an Oregon subject employer at the time of the injury,

(b) The worker provides notification of a secondary job to the insurer within 30 days of the insurer's receipt of the initial claim, and

(c) The worker's temporary disability rate from wages at the primary job does not meet or exceed the maximum rate under section (2) of this rule.

(7) The insurer or the assigned processing administrator must calculate supplemental disability for an eligible worker by adding all earnings the worker received from all subject employment, except the assumed wage from secondary employment for Oregon subject volunteers, under ORS 656.210(2)(a)(B). In no case shall an eligible worker receive less compensation than would be paid if based solely on wages from the primary employer.

(8) If the temporary disability rate from the primary employer does not meet or exceed the maximum rate, the insurer or the assigned processing administrator must combine the weekly wages, determined under OAR 436-060-0025, for each employer and multiply by 66 2/3% (.6667) to establish the combined disability rate up to the maximum rate. This is the base amount on which the worker's combined benefits will be calculated.

(9) No three-day waiting period applies to supplemental disability benefits.

(10) The worker's scheduled days off for the job at which the injury occurred shall be used to calculate and pay supplemental disability.

(11) To establish the combined partial disability benefits when the worker has post injury wages from either job, the insurer or the assigned processing administrator must use all post injury wages from both primary and all secondary employers. The insurer or the assigned processing administrator must calculate the amount due the worker based on the combined wages at injury and combined post injury wages using the temporary partial disability calculation in OAR 436-060-0030. The insurer or the assigned processing administrator must then calculate the amount due from the primary job based only on the primary wages at injury and the primary post injury wages. That amount shall be subtracted from the amount due the worker; the remainder is the supplemental disability amount.

(12) If the worker receives post injury wages from the secondary job equal to or greater than the secondary wages at the time of injury, no supplemental disability is due.

(13) If the worker returns to a job not held at the time of the injury, the insurer or the assigned processing administrator must process supplemental disability under the same terms, conditions and limitations as OAR 436-060-0030.

(14) Supplemental disability may be due on a nondisabling claim even if temporary disability is not due from the primary job. The nondisabling claim will not change to disabling status due to payment of supplemental disability. When supplemental disability payments cease on a nondisabling claim, the insurer or the assigned processing administrator must send the worker written notice advising the worker that their supplemental disability payments have stopped and of the worker's right to appeal that action to the Workers' Compensation Board within 60 days of the notice, if the worker disagrees.

(15) If the insurer has elected to process and pay supplemental disability under ORS 656.210(5)(a), the insurer must determine the worker's on-going entitlement to supplemental disability and must pay the worker supplemental disability simultaneously with any temporary disability due. Reimbursement for supplemental disability paid will be made under OAR 436-060-0500.

(16) If the insurer has elected not to process and pay supplemental disability, the assigned processing administrator must determine the worker's on-going entitlement to supplemental disability and must pay the worker supplemental disability due once each 14 days.

(17) A worker who is eligible for supplemental disability under section (5) of this rule has an on-going responsibility to provide information and documentation to the insurer or the assigned processing administrator, even if temporary disability is not due from the primary job.

(18) If the insurer has elected not to process and pay supplemental disability, the insurer must cooperate and communicate with the assigned processing administrator and both must retain documentation of shared information, as necessary, to coordinate benefits due.

(19) Supplemental disability applies to occupational disease claims in the same manner as to injury claims. Supplemental disability benefits for an occupational disease shall be based on the worker's combined primary and secondary wages at the time there is medical verification the worker is unable to work because of the disability.

(20) When an insurer elects to pay supplemental disability under ORS 656.210(5)(a) and OAR 436-060-0010(20) and receive reimbursement under OAR 436-060-0500, the insurer must maintain a record of supplemental disability paid to the worker, separate from temporary disability paid as a result of the job at injury.

(21) If a worker disagrees with the insurer's or the assigned processing administrator's decision about the worker's eligibility for supplemental disability or the rate of

supplemental disability, the worker may request a hearing before the Hearings Division of the Workers' Compensation Board. If the worker chooses to request a hearing on the insurer's decision concerning the worker's eligibility for supplemental disability, the worker must submit an appeal of the insurer's or the assigned processing administrator's decision within 60 days of the notice in section (5) of this rule. However, the insurer for the primary job is not required to contact the secondary job employer. The worker is responsible to provide any necessary documentation.

(22) An insurer who elects not to process and pay supplemental disability benefits may be sanctioned upon a worker's complaint if the insurer delays sending necessary information to the assigned processing administrator and that delay causes a delay in the worker receiving supplemental disability benefits.

(23) In the event of a third party recovery, previously reimbursed supplemental disability benefits are a portion of the paying agency's lien.

(24) Remittance on recovered benefits shall be made to the department in the quarter following the recovery in amounts determined in accordance with ORS 656.591 and ORS 656.593.

Stat. Auth.: ORS 656.210, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.210, 656.325(5), 656.704, 656.726(4)
Hist.: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0040 Payment of Permanent Partial Disability Compensation

(1) Permanent partial disability exceeding $6,000 may be paid monthly by the insurer. If it is paid monthly, it must be paid at 4.35 times the weekly temporary disability rate at the time of closure.

(2) If a claim is reopened as a result of a new medical condition or an aggravation of the worker's accepted condition(s) and temporary disability is due, any permanent partial disability benefits due must continue to be paid concurrently with temporary disability benefits.

(3) If the worker begins a training program after claim closure, the insurer must suspend the payment of any work disability award, but continue to pay any impairment award.

(4) The insurer must stop temporary disability compensation payments and resume any award payments suspended under ORS 656.268(10) upon the worker's completion or ending of the training, unless the worker is not then medically stationary. If no award payment remains due, temporary disability compensation payments must continue pending a subsequent claim closure.

Stat. Auth.: ORS 656.268(9), 656.704, and 656.726(4)
Stats. Implemented: ORS 656.268(10), 656.704, and 656.726(4)
Hist.: Amended 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0045 Payment of Compensation During Worker Incarceration

(1) A worker is not eligible to receive temporary disability compensation for periods of time during which the worker is incarcerated for commission of a crime. All other compensation benefits must be provided the worker as if the worker were not incarcerated, except as provided in OAR 436-120. For the purpose of this rule:

(a) A worker is incarcerated for commission of a crime when:

(A) In pretrial detention, or

(B) Imprisoned following conviction for a crime.

(b) A worker is not incarcerated if the worker is on parole or work release status.

(2) Temporary disability compensation, if due and payable, must be paid the worker within 14 days of the date the insurer becomes aware the worker is no longer incarcerated.

(3) A worker who is incarcerated shall have the same right to claim closure under ORS 656.268 as a worker who is not incarcerated. Any permanent disability awarded must be paid the same as if the worker were not incarcerated.

Stat. Auth.: ORS 656.160, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.160, 656.704, and 656.726(4)
Hist.: Amended 10/26/04 as WCD Admin. Order 04-064, eff. 1/1/05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0055 Payment of Medical Services on Nondisabling Claims; Employer/Insurer Responsibility

Under ORS 656.262(5) the director will establish the maximum reimbursable amount for medical services. The maximum reimbursable amount will be published annually by Bulletin No. 345. The costs of medical services for nondisabling claims must first be paid by the insurer. Then the insurer may be reimbursed by the employer if the employer so chooses. Such choice does not relieve the employers of their claim reporting requirements or the insurers of their responsibility to determine entitlement to benefits and process the claims accurately and timely. Also, when paid by the employer, such costs cannot in any way be used to affect the employer's experience rating modification or otherwise be charged against the employer. To enable the director to ensure these conditions are met, insurers and employers must comply with the following process and procedures:

(1) Notwithstanding the choice made by the employer under section (2) of this rule, the employer and insurer must process the nondisabling claims in accordance with all statutes and rules governing claims processing. The employer, however, may reimburse the medical service costs paid by the insurer if the employer has chosen to make such payments. The method and manner of reimbursement by the employer shall be as prescribed in section (3) of this rule. In no case, however, shall the employer have less than 30 days to reimburse the insurer.

(2) Prior to the commencement of each policy year, the insurer must send a notice to the insured or prospective insured, advising of the employer's right to reimburse medical service costs up to the maximum amount established by the director on accepted, nondisabling claims. The notice must advise the employer:

(a) Of the procedure for making such payments as outlined in section (3) of this rule;

(b) Of the general impact on the employer if the employer chooses to make such payments;

(c) That the employer is choosing not to participate if the employer does not respond in writing within 30 days of receipt of the insurer's notice;

(d) That the employer's written election to participate in the reimbursement program remains in effect, without further notice from the insurer, until the employer advises otherwise in writing or is no longer insured by the insurer; and

(e) That the employer may participate later in the policy period upon written request to the insurer, however, the earliest reimbursement period shall be the first completed period, established under subsection (3)(a) of this rule, following receipt of the employer's request.

(3) If the employer wishes to make such reimbursement, and so advises the insurer in writing, the procedure for reimbursement shall be:

(a) Within 30 days following each three month period after policy inception or a period mutually agreed upon by the employer and insurer, the insurer must provide the employer with a list of all accepted nondisabling claims for which payments were made during that period and the respective cost of each claim.

(b) The employer, no later than 30 days after receipt of the list, must identify those claims and the dollar amount the employer wishes to pay for that period and reimburse the insurer accordingly.

(c) Failure by the employer to reimburse the insurer within the 30 days allowed by subsection (3)(b) of this rule shall be deemed notice to the insurer that the employer does not wish to make a reimbursement for that period.

(d) Notwithstanding subsection (3)(b) of this rule, the employer and insurer may, by written agreement, establish a period in excess of thirty (30) days for the employer to reimburse the insurer.

(e) The insurer shall continue to bill the employer for any payments made on the claims within 27 months of the inception of the policy period. Any further billing and reimbursement will be made only by mutual agreement between the employer and the insurer.

(4) Insurers must maintain records of amounts reimbursed by employers for medical services on nondisabling claims. Insurers, however, shall not modify an employer's experience rating or otherwise make charges against the employer for any medical services reimbursed by the employer. For employers on retrospective rated plans, medical costs paid by the employer on nondisabling claims must be included in the retrospective premium calculation, but the amount paid by the employer shall be applied as credits against the resulting retrospective premium.

(5) If a claim changes from a nondisabling to a disabling claim and the insurer has recovered reimbursement from the employer for medical costs billed by the insurer prior to the change, the insurer shall exclude those amounts reimbursed from any experience rating, or other individual or group rating plans of the employer. If the employer is on a retrospective rated plan, premium calculation shall be as provided in section (4) of this rule.

(6) Insurers who do not comply with the requirements of this rule or in any way prohibit an employer from reimbursing the insurer under section (3) of this rule, shall be subject to a penalty as provided by OAR 436-060-0200(7).

(7) Self-insured employers must maintain records of all amounts paid for medical services on nondisabling claims in accordance with OAR 436-050-0220. When reporting loss data for experience rating, the self-insured may exclude costs for medical services paid on nondisabling claims in amounts not to exceed the maximum amount established by the director.

Stat. Auth.: ORS 656.262(5), 656.704, 656.726(4), and 656.745
Stats. Implemented: ORS 656.262(5) (ch. 518, OL 2007), 656.704, and 656.726(4)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-064, eff. 1/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0060 Lump Sum Payment of Permanent Partial Disability Awards

(1) Under ORS 656.230, in all cases where an award for permanent partial disability does not exceed $6,000, the insurer must pay all of the award to the worker in a lump sum. When the award for permanent partial disability exceeds $6,000, the insurer may approve an application from the worker or worker's representative for lump sum payment of all or part of the award. The insurer may deny the request for lump sum payment if any of the following apply:

(a) The worker has not waived the right to appeal the adequacy of the award;

(b) The award has not become final by operation of law;

(c) The payment of compensation has been stayed pending a request for hearing or review under ORS 656.313; or

(d) The worker is enrolled and actively engaged in training according to the rules adopted pursuant to ORS 656.340 and 656.726. For dates of injury prior to January 1, 2005, the insurer may not approve a request for lump sum payment of unscheduled permanent disability. For dates of injury on or after January 1, 2005, the insurer may not approve a request for lump sum payment of work disability when the worker:

(A) Has been found eligible for a vocational training program and will start the program within 30 days of the date of the decision on the lump sum request;

(B) Is actively enrolled and engaged in a vocational training program under OAR 436-120; or

(C) Has temporarily withdrawn from such a program.

(2) When an insurer receives a request for a lump sum application from the worker or the worker's representative, the insurer must send the lump sum application, Form 1174, to the requestor within ten business days.

(3) For the purpose of this rule, each opening of the claim is considered a separate claim and any subsequent permanent partial disability award from a claim reopening is a new and separate award. Additional award of permanent partial disability obtained through the appeal process is considered

part of the total cumulative award for the open period of that claim.

(4) If the insurer agrees with the worker's request for lump sum payment of a permanent partial disability award in excess of $6,000, they must make the lump sum payment within 14 days of receipt of the signed application.

(5) If the insurer disagrees with the worker's request for lump sum payment of a permanent partial disability award in excess of $6,000, the insurer must respond to the requestor within 14 days of receiving the request explaining the reason for denying the lump sum request.

(6) A lump sum payment ordered in a litigation order or which is a part of a Claim Disposition Agreement under ORS 656.236 does not require further approval by the insurer.

(7) When a partial payment is approved by the insurer, it shall be in addition to the regularly scheduled monthly payment. The remaining balance shall be paid under ORS 656.216. Denial or partial approval of a request does not prevent another request by the worker for a lump sum payment of all or part of any remainder of the award, provided additional information is submitted.

Stat. Auth.: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.230, 656.704, and 656.726(4)
Hist.: Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0095 Medical Examinations; Suspension of Compensation; and Independent Medical Examination Notice

(1) The division will suspend compensation by order under conditions set forth in this rule. The worker must have the opportunity to dispute the suspension of compensation prior to issuance of the order. The worker is not entitled to compensation during or for the period of suspension when the worker refuses or fails to submit to, or otherwise obstructs, an independent medical examination reasonably requested by the insurer or the director under ORS 656.325(1). Compensation will be suspended until the examination has been completed. The conditions of the examination shall be consistent with conditions described in OAR 436-010-0265. Any action of a friend or family member which obstructs the examination shall be considered an obstruction of the examination by the worker for the purpose of this rule. The division may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination.

(2) The division will consider requests to authorize suspension of benefits on accepted claims, deferred claims and on denied claims in which the worker has appealed the insurer's denial.

(3) A worker must submit to independent medical examinations reasonably requested by the insurer or the director. The insurer may request no more than three separate independent medical examinations for each open period of a claim, except as provided under OAR 436-010. Examinations after the worker's claim is closed are subject to limitations in ORS 656.268(8).

(4) The insurer may contract with a third party to schedule independent medical examinations. If the third party notifies the worker of a scheduled examination on behalf of the insurer, the appointment notice is required to be sent on the insurer's stationery and must conform with the requirements of OAR 436-060-0095(5).

(5) If an examination is scheduled by the insurer or by another party at the request of the insurer, the worker and the worker's attorney shall be simultaneously notified in writing of the scheduled medical examination under ORS 656.331. The notice shall be sent at least 10 days prior to the examination. The notice sent for each appointment, including those which have been rescheduled, must contain the following:

(a) The name of the examiner or facility;

(b) A statement of the specific purpose for the examination and, identification of the medical specialties of the examiners;

(c) The date, time and place of the examination;

(d) The first and last name of the attending physician or authorized nurse practitioner and verification that the attending physician or authorized nurse practitioner was informed of the examination by, at least, a copy of the appointment notice, or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;

(e) If applicable, confirmation that the director has approved the examination;

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

(g) That an amount will be paid equivalent to net lost wages for the period during which it is necessary to be absent from work to attend the medical examination if benefits are not received under ORS 656.210(4) during the absence;

(h) That the worker has the right to have an observer present at the examination, but the observer may not be compensated in any way for attending the exam; however, for a psychological examination, the notice must explain that an observer is allowed to be present only if the examination provider approves the presence of an observer; and

(i) The following notice in prominent or bold face type:

"**You must attend this examination. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the examination. If you fail to attend and do not have a good reason for not attending, or you fail to cooperate with the examination, your workers' compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.325 and OAR 436-060. You may be charged a $100 penalty if you fail to attend without a good reason or if you**

fail to notify the insurer before the examination. The penalty is taken out of future benefits.

If you object to the location of this appointment you must contact the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 or the Ombudsman for Injured Workers at 1-800-927-1271."

(6) The insurer must include with each appointment notice it sends to the worker:

(a) A form for requesting reimbursement; and

(b) The director's brochure, Form 440-3923, "Important Information about Independent Medical Exams."

(7) Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, comply with this rule.

(8) The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service as for a summons. The request must include the following information:

(a) That the insurer requests suspension of benefits under ORS 656.325 and OAR 436-060-0095;

(b) The claim status and any accepted or newly claimed conditions;

(c) What specific actions of the worker prompted the request;

(d) The dates of any prior independent medical examinations the worker has attended in the current open period of the claim and the names of the examining physicians or facilities, or a statement that there have been no prior examinations, whichever is appropriate;

(e) A copy of any approvals given by the director for more than three independent medical examinations, or a statement that no approval was necessary, whichever is appropriate;

(f) Any reasons given by the worker for failing to comply, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;

(g) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the exam received by the insurer from the worker or the worker's representative will be sufficient documentation with which to request suspension;

(h) A copy of the letter required in section (5) and a copy of any written verification received under subsection (8)(g);

(i) Any other information which supports the request; and

(j) The following notice in prominent or bold face type:

"**Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the mailing date of this request. If the division grants this request, you may lose all or part of your benefits. If your claim has not yet been accepted, your future benefits, if any, will be jeopardized.**"

(9) If the division consents to suspend compensation, the suspension shall be effective from the date the worker fails to attend an examination or such other date the division deems appropriate until the date the worker undergoes an examination scheduled by the insurer or director. Any delay in requesting consent for suspension may result in authorization being denied or the date of authorization being modified.

(10) The insurer must assist the worker in meeting requirements necessary for the resumption of compensation payments. When the worker has undergone the independent medical examination, the insurer must verify the worker's participation and reinstate compensation effective the date of the worker's compliance.

(11) If the worker makes no effort to reinstate compensation in an accepted claim within 60 days of the mailing date of the consent to suspend order, the insurer must close the claim under OAR 436-030-0034(7).

(12) If the division denies the insurer's request for suspension of compensation, it shall promptly notify the insurer of the reason for denial. Failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.

(13) The division may also take the following actions concerning the suspension of compensation:

(a) Modify or set aside the order of consent before or after filing of a request for hearing.

(b) Order payment of compensation previously suspended where the division finds the suspension to have been made in error.

(c) Reevaluate the necessity of continuing a suspension.

(14) An order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division of the Workers' Compensation Board.

Stat. Auth: ORS 656.325, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.325, 656.704, and 656.726(4)
Hist.: Amended 3/1/11 as Admin. Order 11-052, eff. 4/1/11
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0105 Suspension of Compensation for Insanitary or Injurious Practices, Refusal of Treatment or Failure to Participate in Rehabilitation; Reduction of Benefits

(1) The division will suspend compensation by order under conditions set forth in this rule. The worker must have the opportunity to dispute the suspension of compensation prior to issuance of the order. The worker is not entitled to compensation during or for the period of suspension under ORS 656.325(2) when the worker commits insanitary or injurious acts which imperil or retard recovery; refuses to submit to medical or surgical treatment reasonably required to

promote recovery; or fails or refuses to participate in a physical rehabilitation program.

(2) The insurer must demand in writing the worker either immediately cease actions which imperil or retard recovery or immediately begin to change the inappropriate behavior and participate in activities needed to help the worker recover from the injury. Such actions include insanitary or injurious practices, refusing essential medical or surgical treatment, or failing to participate in a physical rehabilitation program. Each time the insurer sends such a notice to the worker, the written demand must contain the following information, and a copy shall be sent simultaneously to the worker's attorney and attending physician:

(a) A description of the unacceptable actions;

(b) Why such conduct is inappropriate, including the fact that the conduct is harmful or retards the worker's recovery, as appropriate;

(c) The date by which the inappropriate actions must stop, or the date by which compliance is expected, including what the worker must specifically do to comply; and,

(d) The following notice of the consequences should the worker fail to correct the problem, in prominent or bold face type:

"If you continue to do insanitary or injurious acts beyond the date in this letter, or fail to consent to the medical or surgical treatment which is needed to help you recover from your injury, or fail to participate in physical rehabilitation needed to help you recover as much as possible from your injury, then we will request the suspension of your workers' compensation benefits. In addition, you may also have any permanent disability award reduced in accordance with ORS 656.325 and OAR 436-060."

(3) For the purposes of this rule, failure or refusal to accept medical treatment means the worker fails or refuses to remain under a physician's or authorized nurse practitioner's care or abide by a treatment regimen. A treatment regimen includes, but is not limited to a prescribed diet, exercise program, medication or other activity prescribed by the physician or authorized nurse practitioner that is designed to help the worker reach maximum recovery and become medically stationary.

(4) The insurer must verify whether the worker complied with the request for cooperation on the date specified in subsection (2)(c). If the worker initially agrees to comply, or complies and then refuses or fails to continue doing so, the insurer is not required to send further notice before requesting suspension of compensation.

(5) The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service as for a summons. The request must include the following information:

(a) That the request for suspension is made in accordance with ORS 656.325 and OAR 436-060-0105;

(b) A description of the actions of the worker that prompted the request, including whether such actions continue;

(c) Any reasons offered by the worker to explain the behavior, or a statement that the worker has not provided any reasons, whichever is appropriate;

(d) How, when, and with whom the worker's failure or refusal was verified;

(e) A copy of the letter required in section (2);

(f) Any other relevant information including, but not limited to; chart notes, surgical or physical therapy recommendations/prescriptions, and all physician or authorized nurse practitioner recommendations; and

(g) The following notice in prominent or bold face type:

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the mailing date of this request. If the division authorizes suspension of your compensation and you do not correct your unacceptable actions or show us a good reason why they should be considered acceptable, we will close your claim."

(6) Any delay in obtaining confirmation 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 confirmation or the date the request is received by the division.

(7) If the division concurs with the request, it shall issue an order suspending compensation from a date established under section (5) until the worker complies with the insurer's request for cooperation. Where the worker is suspended for a pattern of noncooperation, the division may require the worker to demonstrate cooperation before restoring compensation.

(8) The insurer must monitor the claim to determine if and when the worker complies with the insurer's requests. When cooperation resumes, payment of compensation must resume effective the date cooperation was resumed.

(9) The insurer must make all reasonable efforts to assist the worker to restore benefits when the worker demonstrates the willingness to make such efforts.

(10) If the worker makes no effort to reinstate benefits within 60 days of the mailing date of the consent order, the insurer must close the claim under OAR 436-030-0034.

(11) If the division denies the insurer's request for suspension of compensation, it shall promptly notify the insurer of the reason for denial. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.

(12) The division may also take the following actions concerning the suspension of compensation:

(a) Modify or set aside the order of consent before or after filing of a request for hearing.

(b) Order payment of compensation previously suspended where the division finds the suspension to have been made in error.

(c) Reevaluate the necessity of continuing a suspension.

(13) An order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division of the Workers' Compensation Board.

(14) The director may reduce any benefits awarded the worker under ORS 656.268 when the worker has unreasonably failed to follow medical advice, or failed to participate in a physical rehabilitation or vocational assistance program prescribed for the worker under ORS chapter 656 and OAR chapter 436. Such benefits must be reduced by the amount of the increased disability reasonably attributable to the worker's failure to cooperate. When an insurer submits a request to reduce benefits under this section, the insurer must:

(a) Specify the basis for the request;

(b) Include all supporting documentation;

(c) Send a copy of the request, including the supporting documentation, to the worker and the worker's representative, if any, by certified mail; and

(d) Include the following notice in prominent or bold face type:

"Notice to worker: If you think this request to reduce your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the mailing date of this request. If the division grants this request, you may lose all or part of your benefits."

(15) The division shall promptly make a decision on a request to reduce benefits and notify the parties of the decision. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the request to reduce benefits.

Stat. Auth.: ORS 656.325, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.325, 656.704, and 656.726(4)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0135 Injured Worker, Worker Representative Responsible to Assist in Investigation; Suspension of Compensation and Notice to Worker

(1) When the worker refuses or fails to cooperate in an investigation of an initial claim for compensation, a claim for a new medical condition, a claim for an omitted medical condition, or an aggravation claim as required by ORS 656.262(14), the division will suspend compensation under ORS 656.262(15) by order under conditions set forth in this rule. The division may determine whether special circumstances exist that would not warrant suspension of compensation for failure to cooperate with an investigation. The worker must have the opportunity to submit information disputing the insurer's request for suspension of compensation prior to issuance of the order.

(2) A worker must submit to and fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques reasonably requested by the insurer. For the purposes of this rule, "personal and telephonic interviews" may be audio or video taped by one or more of the parties if prior written notice is given of the intent to record or tape an interview.

(3) The division will consider requests for suspension of benefits under ORS 656.262(15) only after the insurer has notified the injured worker in writing of the worker's obligation to cooperate as required by section (4) of this rule and only in claims where there has been no acceptance or denial issued.

(4) For suspension of benefits to be granted under this rule, the insurer must notify the worker in writing that an interview or deposition has been scheduled, or of other investigation requirements, and must give the worker at least 14 days to cooperate. The notice must be sent to the worker and copied to the worker's attorney, if represented, and must advise the worker of the date, time and place of the interview and/or any other reasonable investigation requirements. If the insurer contracts with a third party, such as an investigation firm, to investigate the claim, the notice shall be on the insurer's stationery and must conform with the requirements of this section. The notice must inform the worker that the interview, deposition, or any other investigation requirements are related to the worker's compensation claim. The notice must also contain the following statement in prominent or bold face type:

"The workers' compensation law requires injured workers to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers are required to submit to and fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. If you fail to reasonably cooperate with the investigation of this claim, payment of your compensation benefits may be suspended and your claim may be denied in accordance with ORS 656.262 and OAR 436-060."

(5) The request for suspension must be sent to the division after the 14 days in section (4) have expired. Any delay in requesting suspension may result in authorization being denied. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service. The request must include the following information sufficient to show the worker's failure to cooperate:

(a) That the insurer requests suspension of benefits under ORS 656.262(15) and this rule;

(b) Documentation of the specific actions of the worker or worker's representative that prompted the request;

(c) Any reasons given by the worker for failure to comply, or a statement that the worker has not given any reasons, whichever is appropriate;

(d) A copy of the notice required in section (4) of this rule; and

(e) All other pertinent information, including, but not limited to, a copy of the claim for a new or omitted condition when that is what the insurer is investigating.

(6) After receiving the insurer's request as required in section (5) of this rule, the division will promptly notify all parties that the worker's benefits will be suspended in five working days unless the worker or the worker's attorney contacts the division by telephone or mails a letter documenting that the failure to cooperate was reasonable or unless the insurer notifies the division that the worker is now cooperating. The notice of the division will also advise that the insurer's obligation to accept or deny the claim within 60 days is suspended unless the insurer's request is filed with the division after the 60 days to accept or deny the claim has expired.

(7) If the worker cooperates after the insurer has requested suspension, the insurer must notify the division immediately to withdraw the suspension request. The division will notify all the parties. An order may be issued identifying the dates during which the insurer's obligation to accept or deny the claim was suspended.

(8) If the worker documents the failure to cooperate was reasonable the division will not suspend payment of compensation. However, an order may be issued identifying the dates during which the insurer's obligation to accept or deny the claim was suspended.

(9) If the worker has not documented that the failure to cooperate was reasonable, the division will issue an order suspending all or part of the payment of compensation to the worker. The suspension will be effective the fifth working day after notice is provided by the division as required by section (6) of this rule. The suspension of compensation shall remain in effect until the worker cooperates with the investigation. The worker and insurer must notify the division immediately when the worker cooperates with the investigation. If the worker makes no effort to reinstate compensation within 30 days of the date of the notice, the insurer may deny the claim under ORS 656.262(15) and OAR 436-060-0140(10).

(10) Under ORS 656.262 (14), an insurer who believes that a worker's attorney's unwillingness or unavailability to participate in an interview is unreasonable may notify the director in writing and the division will consider assessment of a civil penalty against the attorney of not more than $1,000. The worker's attorney must have the opportunity to dispute the allegation prior to the issuance of a penalty. Notice under this section must be sent to the division. A copy of the notice must be sent simultaneously to the worker and the worker's attorney. Notice to the division by the insurer must contain the following information:

(a) What specific actions of the attorney prompted the request;

(b) Any reasons given by the attorney for failing to participate in the interview; and

(c) A copy of the request for interview sent to the attorney.

(11) Failure to comply with the requirements of this rule will be grounds for denial of the insurer's request.

Stat. Auth.: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.262 (Oregon Laws 2009, ch. 526), 656.704, 656.726(4)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0137 Vocational Evaluations; and Suspension of Compensation

(1) A worker receiving permanent total disability benefits must attend a vocational evaluation reasonably requested by the insurer or the director. The insurer may request no more than three separate vocational evaluations, except as provided under this rule.

(2) When the insurer has obtained the three vocational evaluations allowed under ORS 656.206 and wishes to require the worker to attend an additional evaluation, the insurer must first request authorization from the director. Insurers that fail to first request authorization from the director may be assessed a civil penalty. The process for requesting authorization is as follows:

(a) The insurer must submit a request for authorization to the director in a form and format as prescribed by the director, which includes but is not limited to: the reasons for an additional vocational evaluation; the conditions to be evaluated; dates, times, places, and purposes of previous evaluations; copies of previous vocational evaluation notification letters to the worker; and any other information requested by the director; and

(b) The insurer must provide a copy of the request to the worker and the worker's attorney.

(3) The director will review the request and determine if additional information is needed. Upon receipt of a request for additional information from the director, the parties will have 14 days to respond. If the parties do not provide the requested information, the director will approve or disapprove the request for authorization based on available information.

(4) The director's decision approving or denying more than three vocational evaluations may be appealed to the Hearings Division of the Workers' Compensation Board within 60 days of the order.

(5) For purposes of determining the number of insurer required vocational evaluations, any evaluations scheduled but not completed are not counted as a statutory vocational evaluation.

(6) The insurer may contract with a third party to schedule vocational evaluations. If the third party notifies the worker of a scheduled evaluation on behalf of the insurer, the third party must send the notice on the insurer's stationery and the notice must conform with the requirements of OAR 436-060-0137(7).

(7) The notice must be sent to the worker at least 10 days prior to the evaluation. The notice sent for each evaluation, including those which have been rescheduled, must contain the following:

(a) The name of the vocational assistance provider or facility;

(b) A statement of the specific purpose for the evaluation;

(c) The date, time and place of the evaluation;

(d) The first and last name of the attending physician or authorized nurse practitioner or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;

(e) If applicable, confirmation that the director has approved the evaluation;

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

(g) The following notice in prominent or bold face type:

"You must attend this vocational evaluation. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the evaluation. If you fail to attend or fail to cooperate, or do not have a good reason for not attending, your compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.206 and OAR 436-060. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or the Ombudsman for Injured Workers at 1-800-927-1271."

(8) The insurer must pay the costs of the vocational evaluation and related services reasonably necessary to allow the worker to attend the evaluation. Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, comply with this rule.

(9) When the worker refuses or fails to attend, or otherwise obstructs, a vocational evaluation reasonably requested by the insurer or the director under ORS 656.206, the division may suspend the worker's compensation.

(10) The insurer must send the request for suspension to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service. The request must include the following information:

(a) That the insurer requests suspension of benefits under ORS 656.206 and OAR 436-060-0137;

(b) What specific actions of the worker prompted the request;

(c) The dates of any prior vocational evaluations the worker has attended and the names of the vocational assistance provider or facilities, or a statement that there have been no prior evaluations, whichever is appropriate;

(d) A copy of any approvals given by the director for more than three vocational evaluations, or a statement that no approval was necessary, whichever is appropriate;

(e) Any reasons given by the worker for failing to attend, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;

(f) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the vocational evaluation received by the insurer from the worker or the worker's representative will be sufficient documentation with which to request suspension;

(g) A copy of the letter required in section (7) and a copy of any written verification received under subsection (10)(f);

(h) Any other information which supports the request; and

(i) The following notice in prominent or bold face type:

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the mailing date of this request. If the division grants this request, you may lose all or part of your benefits."

(11) If the insurer fails to comply with this rule, the division may deny the request for suspension.

(12) If the division suspends compensation, the suspension will be effective from the date the worker fails to attend a vocational evaluation or such other date the division deems appropriate until the date the worker attends the evaluation. The worker is not entitled to compensation during or for the period of suspension. Any delay in requesting suspension may result in suspension being denied or the date of suspension being modified.

(13) The insurer must assist the worker to meet requirements necessary for the resumption of compensation payments. When the worker has attended the vocational evaluation, the insurer must verify the worker's participation and resume compensation effective the date of the worker's compliance.

(14) The division may also:

(a) Modify or set aside the suspension order before or after filing of a request for hearing;

(b) Order payment of compensation previously suspended where the division finds the suspension to have been made in error; or

(c) Reevaluate the necessity of continuing a suspension.

(15) A suspension order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division of the Workers' Compensation Board.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.206
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0140 Acceptance or Denial of a Claim

(1) The insurer is required to conduct a "reasonable" investigation based on all available information in ascertaining whether to deny a claim. A reasonable investigation is

whatever steps a reasonably prudent person with knowledge of the legal standards for determining compensability would take in a good faith effort to ascertain the facts underlying a claim, giving due consideration to the cost of the investigation and the likely value of the claim.

(2) In determining whether an investigation is reasonable, the director will only look at information contained in the insurer's claim record at the time of denial. The insurer may not rely on any fact not documented in the claim record at the time of denial to establish that an investigation was reasonable.

(3) The insurer must give the claimant written notice of acceptance or denial of a claim within:

(a) 90 days after the employer's notice or knowledge of an initial claim or the insurer's receipt of a form 827 signed by the worker or the worker's representative and the worker's attending physician indicating an aggravation claim or written notice of a new medical condition claim for claims with a date of injury prior to January 1, 2002; or

(b) 60 days after the employer's notice or knowledge of an initial claim or the insurer's receipt of a form 827 signed by the worker or the worker's representative and the worker's attending physician indicating an aggravation claim or written notice of a new medical or omitted condition claim for claims with a date of injury on or after January 1, 2002; or

(c) 90 days after the employer's notice or knowledge of the claim if the worker challenges the location of an independent medical examination under OAR 436-010-0265 and the challenge is upheld, regardless of the date of injury.

(4) The director may assess a penalty against any insurer delinquent in accepting or denying a claim beyond the days required in (3) in excess of 10 percent of their total volume of reported disabling claims during any quarter.

(5) A notice of acceptance must comply with ORS 656.262(6)(b) and the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law, OAR chapter 438. It must include a current mailing date, be addressed to the worker, be copied to the worker's representative, if any, and the worker's attending physician, and describe to the worker:

(a) What conditions are compensable;

(b) Whether the claim is disabling or nondisabling;

(c) The Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that the injury is nondisabling by requesting the insurer review the status;

(d) The employment reinstatement rights and responsibilities under ORS chapter 659A;

(e) Assistance available to employers from the Reemployment Assistance Program under ORS 656.622;

(f) That claim related expenses paid by the worker must be reimbursed by the insurer when requested in writing and accompanied by sales slips, receipts, or other reasonable written support, for meals, lodging, transportation, prescriptions and other related expenses. The worker must be advised of the two year time limitation to request reimbursement as provided in OAR 436-009-0025(1) and that reimbursement of expenses may be subject to a maximum established rate;

(g) That if the worker believes a condition has been incorrectly omitted from the notice of acceptance, or the notice is otherwise deficient, the worker must first communicate the objection to the insurer in writing specifying either that the worker believes the condition has been incorrectly omitted or why the worker feels the notice is otherwise deficient; and

(h) That if the worker wants the insurer to accept a claim for a new medical condition, the worker must put the request in writing, clearly identify the condition as a new medical condition, and request formal written acceptance of the condition.

(6) On fatal claims, the notice must be addressed "to the estate of" the worker and the requirements in (5)(a) through (h) shall not be included.

(7) The first acceptance issued on the claim must contain the title "Initial Notice of Acceptance" near the top of the notice. Any notice of acceptance must contain all accepted conditions at the time of the notice. When an insurer closes a claim, it must issue an "Updated Notice of Acceptance at Closure" under OAR 436-030-0015. Additionally, when reopening a claim, the notice of acceptance must specify the condition(s) for which the claim is being reopened. Under ORS 656.262(6)(b)(F) the insurer must modify acceptance from time to time as medical or other information changes. An insurer must issue a "Modified Notice of Acceptance" (MNOA) when they:

(a) Accept a new or omitted condition: on a nondisabling claim, while a disabling claim is open or after claim closure;

(b) Accept an aggravation claim;

(c) Change the disabling status of the claim; or

(d) Amend a notice of acceptance, including correcting a clerical error.

(8) Notwithstanding OAR 436-060-0140(7)(d), to correct an omission or error in an "Updated Notice of Acceptance at Closure"(UNOA), under OAR 436-030-0015(1)(c)(D), the insurer must add the word "Corrected" to the UNOA.

(9) When an insurer accepts a new or omitted condition on a closed claim, the insurer must reopen the claim and process it to closure under ORS 656.262 and 656.267.

(10) A notice of denial must comply with the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law, OAR chapter 438, and must:

(a) Specify the factual and legal reasons for the denial, including the worker's right to request a Worker Requested Medical Examination and a specific statement indicating if the denial was based in whole or part on an independent medical examination, under ORS 656.325, and one of the following statements, as appropriate:

(A) "Your attending physician agreed with the independent medical examination report"; or

(B) "Your attending physician did not agree with the independent medical examination report"; or

(C) "Your attending physician has not commented on the independent medical examination report"; and

(b) Inform the worker of the Expedited Claim Service and of the worker's right to a hearing under ORS 656.283.

(c) If the denial is under ORS 656.262(15), it must inform the worker that a hearing may occur sooner if the worker requests an expedited hearing under ORS 656.291.

(d) If paragraph (10)(a)(B) above applies, the denial notice must also include the division's Web site address and toll free Infoline number for the worker's use in obtaining a brochure about the Worker Requested Medical Examination.

(11) The insurer must send notice of the denial to each provider of medical services and health insurance when compensability of any portion of a claim for medical services is denied when any of the following applies:

(a) The denial is sent to the worker;

(b) Within 14 days of receipt of any billings from medical providers not previously notified of the denial. The notice must advise the medical provider of the status of the denial; or

(c) Within 60 days of the date when compensability of the claim has been finally determined or when disposition of the claim has been made. The notification must include the results of the proceedings under ORS 656.236 or 656.289(4) and the amount of any settlement.

(12) The insurer must pay compensation due under ORS 656.262 and 656.273 until 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 employer may elect to pay compensation under this section in lieu of the insurer doing so. The insurer must report to the division payments of compensation made by the employer as if the insurer had made the payment.

(13) Compensation payable to a worker or the worker's beneficiaries while a claim is pending acceptance or denial does not include the costs of medical benefits or burial.

Stat. Auth.: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.262 (Oregon Laws 2009, ch. 526), 656.325, 656.704, and 656.726(4)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0147 Worker Requested Medical Examination

(1) The director shall determine the worker's eligibility for a Worker Requested Medical Examination (Exam) under ORS 656.325(1). The worker is eligible for an exam if the worker has made a timely request for a Workers' Compensation Board hearing on a denial of compensability as required by ORS 656.319(1)(a); and the denial was based on one or more Independent Medical Examination reports with which the attending physician or authorized nurse practitioner disagreed.

(2) The worker must submit a request for the exam to the director. A copy of the request must be sent simultaneously to the insurer or self-insured employer. The request must include:

(a) The name, address, and claim identifying information of the injured worker;

(b) A list of physicians, including name(s) and address(es), who have previously provided medical services to the worker on this claim or who have previously provided medical services to the worker related to the claimed condition(s);

(c) The date the worker requested a hearing and a copy of the hearing request;

(d) A copy of the insurer's denial letter; and

(e) Document(s) that demonstrate that the attending physician or authorized nurse practitioner did not concur with the independent medical examination report(s).

(3) The insurer must, upon written notice from the worker, mail to the director no later than the 14th day following the insurer's receipt of the worker's request, the names and addresses of all physicians or nurse practitioners who have:

(a) Acted as attending physician or authorized nurse practitioner;

(b) Provided medical consultations or treatment to the worker;

(c) Examined the worker at an independent medical examination; or

(d) Reviewed the worker's medical records on this claim. For the purpose of this rule, "Attending Physician" and "Independent Medical Examination" have the meanings defined in OAR 436-010-0005 and 436-010-0265(1), respectively.

(4) Failure to provide the required documentation described in section (3) in a timely manner will subject the insurer to civil penalties under OAR 436-060-0200.

(5) The director will notify all parties in writing of the physician selected, or will provide the worker or the worker's representative a list of appropriate physicians.

(6) If the director provides a list of physicians, the following applies:

(a) The worker's or the worker's representative's response must be in writing, signed, and received by the director within ten business days of providing the list.

(b) The worker or the worker's representative may eliminate the name of one physician from the list.

(c) If the worker or the worker's representative does not respond as provided in this section, the director will select a physician.

(d) The director will notify the parties in writing of the physician selected.

(7) The worker or the worker's legal representative shall schedule the exam with the selected physician and notify the insurer and the Workers' Compensation Board of the scheduled exam date within 14 days of the notification date in (6) of this rule. An unrepresented worker may consult with the Injured Worker Ombudsman for assistance.

(8) The insurer must send the physician the worker's complete medical and diagnostic record on this claim and the

original questions asked of the independent medical examination(s) physician(s) no later than 14 days prior to the date of the scheduled exam. If the diagnostic records are not in the insurer's possession, the insurer must request that the medical provider send the diagnostic records to the selected physician at least 14 days prior to the scheduled exam.

(9) The worker or the worker's representative shall communicate questions related to the compensability denial in writing to be answered by the physician at the exam to the physician at least 14 days prior to the scheduled date of the exam. An unrepresented worker may consult with the Injured Worker Ombudsman for assistance.

(10) Upon completion of the exam the physician must address the original independent medical examination(s) questions and the questions from the worker or the worker's representative under section (9) of this rule and send the report to the worker's legal representative, if any, or the worker, and the insurer within 5 working days.

(11) The insurer must pay the physician selected under this rule in accordance with OAR 436-009. Delivery of medical services to injured workers shall be in accordance with OAR 436-010.

(12) If the worker fails to attend the scheduled Worker Requested Medical Exam, the insurer must pay the physician for the missed examination. The insurer is not required to pay for another examination unless the worker did not attend the missed examination for reasons beyond the worker's reasonable control.

(13) The insurer must reimburse the worker for all necessary related services under ORS 656.325(1).

Stat. Auth.: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.325(1), 656.704, and 656.726(4)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0150 Timely Payment of Compensation

(1) Benefits are deemed paid when addressed to the last known address of the worker or beneficiary and deposited in the U.S. Mail or when funds are transferred to a financial institution for deposit in the worker's or beneficiary's account by approved electronic equivalent. Payments due on a weekend or legal holiday under ORS 187.010 and 187.020 may be paid on the last working day before or the first working day after the weekend or legal holiday. Subsequent payments may revert back to the payment schedule before the weekend or legal holiday.

(2) For the purpose of this rule, legal holidays in the State of Oregon are:

(a) Each Sunday;

(b) New Year's Day on January 1;

(c) Martin Luther King, Jr.'s Birthday on the third Monday in January;

(d) Presidents Day, for the purpose of commemorating Presidents Washington and Lincoln, on the third Monday in February;

(e) Memorial Day on the last Monday in May;

(f) Independence Day on July 4;

(g) Labor Day on the first Monday in September;

(h) Veterans Day on November 11;

(i) Thanksgiving Day on the fourth Thursday in November; and

(j) Christmas Day on December 25.

(k) Each time a holiday, other than Sunday, falls on Sunday, the succeeding Monday is a legal holiday. Each time a holiday falls on Saturday, the preceding Friday is a legal holiday.

(l) Additional legal holidays include every day appointed by the Governor as a legal holiday and every day appointed by the President of the United States as a day of mourning, rejoicing or other special observance only when the Governor also appoints that day as a holiday.

(3) First payment of time loss must be timely. An insurer's performance is in compliance when 90 percent of payments are timely. The director may assess a penalty against an insurer falling below these norms during any quarter.

(4) Compensation withheld under ORS 656.268(13) and (14), and 656.596(2), will not be deemed untimely if the insurer notifies the worker in writing why benefits are being withheld and the amount that must be offset before any further benefits are payable.

(5) Timely payment of temporary disability benefits means the insurer has made payment no later than the 14th day after:

(a) The date of the employer's notice or knowledge of the claim and of the worker's disability, if the attending physician or authorized nurse practitioner has authorized temporary disability. Temporary disability accrued before the date of the employer's notice or knowledge of the claim will be due within 14 days of claim acceptance;

(b) The date the attending physician or authorized nurse practitioner authorizes temporary disability, if the authorization is more than 14 days after the date of the employer's notice or knowledge of the claim and of the worker's disability;

(c) The start of authorized vocational training under ORS 656.268(10), if the insurer has previously closed the claim;

(d) The date the insurer receives medical evidence supported by objective findings that shows the worker is unable to work due to a worsening of the compensable condition under ORS 656.273;

(e) The date of any division order, including, but not limited to, a reconsideration order, that orders payment of temporary disability. If the insurer has appealed a reconsideration order, the appeal stays payment of temporary disability benefits except those that accrue from the date of the order, under ORS 656.313;

(f) The date of a notice of claim closure issued by the insurer that finds the worker entitled to temporary disability;

(g) The date a notice of closure is set aside by a reconsideration order;

(h) The date any litigation authorizing retroactive temporary disability becomes final. Temporary disability accruing from the date of the order must begin no later than the 14th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board is the signature date, and from the courts, it is the date of the appellate judgment;

(i) The date the division refers a claim to the insurer for processing under ORS 656.029;

(j) The date the division refers a noncomplying employer claim to an assigned claims agent under ORS 656.054; or

(k) The date a claim disposition is disapproved by the Board or Administrative Law Judge, if temporary disability benefits are otherwise due;

(l) The date the division designates a paying agent under ORS 656.307;

(m) The date a claim is reclassified from nondisabling to disabling, if temporary disability is due and payable; and

(n) The date an insurer voluntarily rescinds a denial of a disabling claim.

(6) Temporary disability must be paid to within seven days of the date of payment at least once each 14 days. When making payments under OAR 436-060-0020(1), the employer may make subsequent payments of temporary disability concurrently with the payroll schedule of the employer, rather than at 14-day intervals.

(7) Permanent disability must be paid no later than the 30th day after:

(a) The date of a notice of claim closure issued by the insurer;

(b) The date of any litigation order that orders payment of permanent total disability. Permanent total benefits accruing from the date of the order must begin no later than the 30th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board is the mailing date, and from the courts, it is the date of the appellate judgment;

(c) The date of any division order, including, but not limited to, a reconsideration order, that orders payment of compensation for permanent disability;

(d) The date any litigation authorizing permanent partial disability becomes final;

(e) The date a claim disposition is disapproved by the Board or Administrative Law Judge, if permanent disability benefits are otherwise due; or

(f) The date authorized training ends if the worker is medically stationary and any previous award remains unpaid, under ORS 656.268(10) and OAR 436-060-0040(2).

(8) Fatal benefits must be paid no later than the 30th day after:

(a) The date of a notice of acceptance issued by the insurer; or

(b) The date of any litigation order which orders fatal benefits. Fatal benefits accruing from the date of the order must begin no later than the 30th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board is the mailing date, and from the courts, it is the date of the appellate judgment.

(9) The insurer must make subsequent payments of permanent disability and fatal benefits in monthly sequence. The insurer may adjust monthly payment dates, but must inform the beneficiary before making the adjustment. No payment period may exceed one month without the division's prior approval.

(10)(a) When paying temporary disability benefits the insurer must notify the worker or beneficiary in writing of the specific purpose of the payment and the time period that the payment covers.

(b) When issuing the initial payment of permanent disability or fatal benefits the insurer must notify the worker or beneficiary in writing of the specific purpose of the payment, the schedule of future payments, and the time period each payment will cover. The insurer is not required to provide an explanation in writing with each subsequent permanent disability or fatal benefit payment.

(c) The insurer must provide an explanation in writing to the worker or beneficiary when the benefit amount, time period covered, or payment schedule changes.

(11) The insurer must maintain records of compensation paid for each claim where benefits are due and payable.

(12) If the worker submits a request for reimbursement of multiple items and full reimbursement is not made, the insurer must provide specific reasons for non-payment or reduction of each item.

(13) Payment of a Claim Disposition Agreement must be made no later than the 14th day after the Board or Administrative Law Judge mails notice of its approval of the agreement to the parties, unless otherwise stated in the agreement.

(14) Under ORS 656.126(6), when Oregon compensation is more than the compensation under another law for the same injury or occupational disease, or compensation paid the worker under another law is recovered from the worker for the same injury or occupational disease, the insurer must pay any unpaid compensation to the worker up to the amount required by the claim under Oregon law within 14 days of receipt of written documentation supporting the underpayment of Oregon compensation.

Stat. Auth.: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.262(4), 656.268(10), 656.273, 656.278, 656.289, 656.307, 656.313, 656.704, and 656.726(4)
Hist.: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0153 Electronic Payment of Compensation

(1) An insurer may pay benefits through a direct deposit system, automated teller machine card or debit card, or other means of electronic transfer if the worker voluntarily consents. The worker's consent must be obtained prior to initiating electronic payments and may be written or verbal. The insurer

must provide the worker a written confirmation when consent is obtained verbally. The worker may discontinue receiving electronic payments by notifying the insurer in writing.

(2) The worker must receive a copy of the cardholder agreement outlining the terms and conditions under which an automated teller machine card or debit card has been issued prior to or at the time the initial electronic payment is made.

(3) The instrument of payment must be negotiable and payable to the worker for the full amount of the benefit paid, without cost to the worker. The worker must be able to make an initial withdrawal of the entire amount of the benefit paid without delay or cost to the worker.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.262(4) and 84.013
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0155 Penalty to Worker for Untimely Processing

(1) Under ORS 656.262(11), the director may require the insurer to pay an additional amount to the worker as a penalty and an attorney fee to the worker's attorney when the insurer unreasonably delays or unreasonably refuses to pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim.

(2) Requests for penalties and attorney fees under this section must be in writing, stating what benefits, attorney fees or costs have been delayed or remain unpaid, and mailed or delivered to the division within 180 days of the alleged violation. Attorney fees will be awarded under OAR 436-001-0400 to 436-001-0440.

(3) For the purpose of this section, "violation" is either:

(a) A late payment or the nonpayment of any single payment due, in which case a request for penalty must be mailed or delivered to the director within 180 days of the date payment was due; or

(b) A continuous nonpayment or underpayment such as with yearly cost of living increases for temporary disability compensation. In these instances, a request for penalty must be mailed or delivered to the director within 180 days of the date of the last underpayment. All prior underpayments will be considered as one violation, regardless of when the first underpayment occurred.

(4) When notified by the director that additional amounts may be due the worker as a penalty under this rule, the insurer must respond in writing to the division. The response must be mailed or delivered to the division within 21 days of the mailing date of the division's inquiry letter, with copies of the response, including any attachments, sent simultaneously to the worker and the worker's attorney (if represented). If an insurer fails to respond or provides an inadequate response (e.g. failing to answer specific questions or provide requested documents), the director may assess a civil penalty under OAR 436-060-0200. In addition, the director may assess a $50.00 civil penalty under OAR 436-060-0200 if the insurer does not provide copies of the response to the worker or attorney timely.

(5) When no written reason for delay is provided by the insurer as required in section (4) and no reason for the delay is evident from the worker's or division's records, the director will consider the delay unreasonable, unless the worker has provided insufficient information to assess a penalty. In such cases, the director may assess a civil penalty under OAR 436-060-0200.

(6) The director will only consider a penalty issue where the assessment and payment of additional amounts described in ORS 656.262(11) is the sole issue of any proceeding between the parties. If a proceeding on any other issue is initiated before the Hearings Division of the Workers' Compensation Board between the same parties before the director issues an order under this section, and the director is made aware of the proceeding, jurisdiction over the penalty proceeding before the director will immediately rest with the Hearings Division and the director will refer the proceedings to the Hearings Division. If the director has not been made aware of the proceeding before the Hearings Division and issues a penalty order that becomes final, the director's penalty will stand.

(7) The director will use the matrix attached to these rules in Appendix "B" in assessing penalties. When there are no "amounts then due" upon which to assess a penalty, no penalty will be issued under this rule.

(8) Penalties ordered under this rule must be paid to the worker no later than the 30th day after the date of the order, unless the order is appealed. If the order is appealed and later upheld, the penalty will be due within 14 days of the date the order upholding the penalty becomes final. If the insurer does not pay penalties in a timely manner the insurer will be subject to civil penalties under OAR 436-060-0200.

(9) Disputes regarding unreasonable delay or unreasonable refusal to pay compensation, attorney fees or costs or unreasonable delay in acceptance or denial of a claim may be resolved by the parties. In cases where the parties wish to resolve such disputes and the assessment and payment of additional amounts under ORS 656.262(11) is the sole issue of a proceeding between the parties, and the violation(s) occurred within the last 180 days in accordance with section (3), then the parties must submit a stipulation to the division for approval. The stipulation must specify:

(a) The benefits, attorney fees or costs delayed and the amounts;

(b) The time period(s) involved;

(c) If applicable, the name of the medical provider(s) and the date(s) of service(s) relating to medical bills;

(d) The amount of the penalty not to exceed 25 percent of the amount of compensation delayed; and

(e) The attorney fees, if applicable.

(10) Payment of the penalty is due within 14 days after the date the division approves the stipulation, unless otherwise stated in the stipulation. If the insurer does not pay penalties in

a timely manner the insurer will be subject to civil penalties under OAR 436-060-0200.

(11) Any other agreements between the parties to pay a penalty or attorney fee without a stipulation approved by the division will not be acknowledged as a violation as it applies to the matrix attached to these rules.

Stat. Auth.: ORS 656.262(11), 656.704, 656.726(4), and 656.745
Stats. Implemented: ORS 656.262(11), 656.704, and 656.726(4)
Hist.: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0160 Use of Sight Draft to Pay Compensation Prohibited

Insurers shall not use a sight draft to pay 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.

Stat. Auth.: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.704 and 656.726(4)
Hist.: Amended 10/2/02 as WCD Admin. Order 02-059, eff 11/1/02
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0170 Recovery of Overpayment of Benefits

(1) Insurers may recover overpayment of benefits paid to a worker as specified by ORS 656.268(14), unless authority is granted by an Administrative Law Judge or the Workers' Compensation Board.

(2) Insurers may recover an overpayment from any benefits currently due on any claim the worker has with that insurer. Insurers must explain in writing the reason, amount and method of recovery to the worker and the worker's attorney or to the worker's survivors.

(3) When overpaid benefits are offset against monthly permanent partial disability award payments, the recovery shall be from the total amount of the award with the remainder of the award being paid out at 4.35 times the temporary total disability rate and no less than $108.75, starting with the first month's payment.

Stat. Auth.: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.268(12) and (14), 656.704, and 656.726(4)
Hist.: Amended 10/26/04 as WCD Admin. Order 04-064, eff. 1/1/05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0180 Designation and Responsibility of a Paying Agent

(1) For the purpose of this rule:

(a) "Compensable injury" means an accidental injury or damage to a prosthetic appliance, or an occupational disease arising out of and in the course of employment with any Oregon employer, and which requires medical services or results in disability or death.

(b) "Exposure" means a specific incident or period during which a compensable injury may have occurred.

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

(2) The division will designate by order which insurer must pay a claim if the employers and insurers admit that the claim is otherwise compensable, and where there is an issue regarding:

(a) Which subject employer is the true employer of a worker;

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

(c) Which of two or more employers or their insurers is responsible for paying compensation for one or more on-the-job injuries or occupational diseases; or

(d) Which of two or more employers is responsible when there is joint employment.

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

(4) Upon learning of any of the situations described in section (2), the insurer must expedite the processing of the claim by immediately investigating the claim to determine responsibility and whether the claim is otherwise compensable. For the purposes of this rule, insurers identified in a potential responsibility dispute under ORS 656.307 must, upon request, share claim related medical reports and other information without charge pertinent to the injury in order to expedite claim processing. The act of the worker applying for compensation benefits from any employer identified as a party to a responsibility dispute shall constitute authorization for the involved insurers to share the pertinent information in accordance with the criteria and restrictions provided in OAR 436-060-0017 and 436-010-0240. No insurer who shares information in accordance with this rule shall bear any legal liability for disclosure of such information.

(5) Upon learning of any of the situations described in section (2), the insurer must immediately notify any other affected insurers of the situation. Such notice must identify the compensable injury and include a copy of all medical reports and other information pertinent to the injury. The notice must identify each period of exposure which the insurer believes responsible for the compensable injury by the following:

(a) Name of employer;

(b) Name of insurer;

(c) Specific date of injury or period of exposure; and

(d) Claim number, if assigned.

(6) Upon deciding that the responsibility for an otherwise compensable injury cannot be determined, the insurer must request designation of a paying agent by writing to the division and sending a copy of the request to the worker and the worker's representative, if any. The request shall not be contained in or attached to any form or report the insurer is required to submit under OAR 436-060-0010 or in the denial letter to the worker required by OAR 436-060-0140. Such a request, or agreement to designation of a paying agent, is not an admission that the injury is compensably related to that insurer's claim; it is solely an assertion that the injury is compensable against a subject Oregon employer. The insurer's written request to the division must contain the following information:

(a) Identification of the compensable injury(ies);

(b) That the insurer is requesting designation of a paying agent under ORS 656.307;

(c) That the insurer acknowledges the injury is otherwise compensable;

(d) That responsibility is the only issue;

(e) Identification of the specific claims or exposures involved by

(A) Employer,

(B) Insurer,

(C) Date of injury or specific period of exposure, and

(D) Claim number, if assigned;

(f) Acknowledgment that medical reports and other material pertinent to the injury have been provided to the other parties; and

(g) Confirmation the worker has been advised of the actions being taken on the worker's claim.

(7) The division will not designate a paying agent where there remains an issue of whether the injury is compensable against a subject Oregon employer, or if the 60 day appeal period of a denial has expired without a request for hearing being received by the Board or the division receiving a request for a designation of paying agent order, or if an insurer included in the question of responsibility opposes designation of a paying agent because it has received no claim.

(8) When notified by the division that there is a reasonable doubt as to the status of the claim or intent of a denial, the insurer must provide written clarification to the division, the worker, insurers involved and other interested parties within 21 days of the mailing date of the notification. If an insurer fails to respond timely or provides an inadequate response (e.g. failing to answer specific questions or provide requested documents), a civil penalty will be assessed under OAR 436-060-0200.

(9) Insurers receiving notice from the division of a worker's request for designation of a paying agent must immediately process the request in accordance with sections (4) through (6).

(10) Upon receipt of written acknowledgment from the insurers that the only issue is responsibility for an otherwise compensable injury claim, the division will issue an order designating a paying agent under ORS 656.307. The division will designate the insurer with the lowest compensation considering the following factors:

(a) The claim with the lowest temporary total disability rate.

(b) If the temporary total disability rates and the rates per degree of permanent disability are the same, the earliest claim.

(c) If there is no temporary disability or the temporary total disability rates are the same, but the rates per degree of permanent disability are different, the claim with the lowest rate per degree of permanent disability.

(d) If one or more claims have disposed of benefits in accordance with ORS 656.236(1), the claim providing the lowest compensation not released by the claim disposition agreement.

(e) If one claim is under "Own Motion" jurisdiction, the Own Motion claim, even if not the claim with the lowest temporary total disability rate.

(f) If more than one claim is under "Own Motion" jurisdiction, the Own Motion claim with the lowest temporary total disability rate.

(11) By copy of its order, the division will refer the matter to the Workers' Compensation Board to set a proceeding under ORS 656.307 to determine which insurer is responsible for paying benefits to the worker.

(12) The designated paying agent must process the claim as an accepted claim through claim closure under OAR 436-030-0015(9) unless relieved of the responsibility by an order of the Administrative Law Judge or resolution through mediation or arbitration under ORS 656.307(6). The parties to an order under this section shall not settle any part of a claim under ORS 656.236 or 656.289, except to resolve the issue of responsibility, unless prior approval and agreement is obtained from all potential responsible insurers. Resolution of a dispute by mediation or arbitration by a private party cannot obligate the Consumer and Business Services Fund without the director's prior approval. The Consumer and Business Services Fund shall not be obligated when one party declines to participate in a legitimate settlement conference under an ORS 656.307 order. Compensation paid under the order must 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 must be for periods subsequent to periods of disability already paid by any insurer.

(13) After a paying agent is designated, if any of the insurers determine compensability is or will be an issue at hearing, they must notify the division. Any insurer must notify the division and all parties to the order of any change in claim acceptance status after the designation of a paying agent. When the division receives notification of a change in the acceptance of a claim or notification that compensability is an issue after designation of a paying agent, the division shall order termination of any further benefits due from the original order designating a paying agent.

Stat. Auth.: ORS 656.307, 656.704, 656.726(4), and 656.745
Stats. Implemented: ORS 656.307, 656.308, 656.704, and 656.726(4)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0190 Monetary Adjustments Among Parties and Department of Consumer and Business Services

(1) An order of the director under ORS 656.307 and OAR 436-060-0180 applies only to the period prior to the order of the Administrative Law Judge determining the responsible paying party. Payment of compensation made thereafter shall not be recovered from the Consumer and Business Services Fund, unless the director concludes payment was made before the Administrative Law Judge's order was received by the paying agent designated under OAR 436-060-0180. Any monetary adjustment necessary after the Administrative Law Judge's order shall be handled under OAR 436-060-0195.

(2) When all litigation on the issue of responsibility is final, the insurer ultimately held to be responsible must, prior to paying any compensation, contact any nonresponsible insurer to learn what compensation has already been paid. When contacted by the responsible insurer, the nonresponsible insurer must provide the requested information necessary for the responsible insurer to make a timely payment to the worker, medical providers or others, but in any case no later than 20 days after the date of the notification. Failure to respond to the responsible insurer's inquiry in a timely manner may result in non-reimbursement otherwise due from the responsible insurer or from the Consumer and Business Services Fund.

(3) The responsible insurer must reimburse any nonresponsible insurers for compensation the nonresponsible insurer paid which the responsible insurer is responsible for, but has not already paid within 30 days of receiving sufficient information to adequately determine the benefits paid and the relationship to the condition(s) involved. Any balance remaining due the worker, medical providers or others must be paid in a timely manner under OAR 436-009 and 436-060-0150. Payment of compensation which results in duplicate payment to the worker, medical providers or others as a result of failing to contact the nonresponsible insurer shall not release the responsible insurer from the requirement to reimburse any nonresponsible insurers for its costs.

(4) The division shall direct any necessary monetary adjustment between the parties involved which is not otherwise ordered by the Administrative Law Judge or voluntarily resolved by the parties, but shall not order an insurer to pay compensation over and beyond that required by law, as it relates to the insurer's claim, except in the situation described in section (3). Failure to make monetary adjustments within 30 days of an order by the division will subject the insurer to civil penalties under OAR 436-060-0200. Only compensation paid as a result of an order by the director under OAR 436-060-0180 and consistent with this rule shall be recoverable from the Consumer and Business Services Fund when such compensation is not reimbursed to the nonresponsible insurer by the responsible insurer.

(5) When the division determines improper or untimely claim processing by the designated paying agent has resulted in unnecessary costs, the division may deny reimbursement from the responsible insurer and the Consumer and Business Services Fund.

Stat. Auth.: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.307(3), 656.704, and 656.726(4)
Hist.: Amended 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0195 Miscellaneous Monetary Adjustments Among Insurers

(1) The director may order monetary adjustments between insurers under authority provided by ORS 656.726(4) and 656.202 where a claimant has a right to compensation, but there is a dispute between insurers that does not fall under the director's authority in ORS 656.307 and OAR 436-060-0190. Any failure to obtain reimbursement from an insurer under this rule shall not be recoverable from the Consumer and Business Services Fund. The purpose of this rule is to ensure the claimant properly receives all compensation due under the workers' compensation law, but is not unduly compensated for more than the law intended.

(2) When any litigation on issues in question is final, insurers must make any necessary monetary adjustments among themselves consistent with the determination of coverage for compensation paid to the worker, medical providers and others for which they are responsible and payment has not already been made, within 30 days of receiving sufficient information to adequately determine the benefits paid and the relationship to the condition(s) involved. Any balance due after making such adjustments must be paid in a timely manner to the worker, medical providers and others under OAR 436-009 and 436-060-0150.

(3) The division may direct any necessary monetary adjustment between parties, but shall not order an insurer to pay compensation over and beyond that required by law, as it relates to the insurer's claim, except where an insurer unduly compensates a claimant while having knowledge such compensation has already been paid by another insurer. Notwithstanding, each insurer has its own independent obligation to process its claim and pay interim compensation due until the claim is either accepted or denied. When notified by the division that a dispute over monetary adjustment exists the insurer must provide a written response to questions or issues raised, including supporting documentation, to the division, insurers involved and other interested parties within 21 days of the mailing date of the notification.

(4) Failure to respond to the division's inquiries or make monetary adjustments within 30 days of an order by the division will subject the insurer to civil penalties under OAR 436-060-0200.

(5) When the division determines improper or untimely claim processing by an insurer resulted in unnecessary costs, the division may deny monetary adjustment between the insurers.

Stat. Auth.: ORS 656.704, 656.726(4), and 656.745
Stats. Implemented: ORS 656.704 and 656.726(4)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0200 Assessment of Civil Penalties

(1) The director through the division and under ORS 656.745 will assess a civil penalty against an employer or insurer that intentionally or repeatedly induces claimants for compensation to fail to report accidental injuries, causes employees to collect accidental injury claims as off-the-job injury claims, persuades claimants to accept less than the compensation due or makes it necessary for claimants to resort to proceedings against the employer to secure compensation due.

(2) A penalty under section (1) will only be assessed after all litigation on the matter has become final by operation of the law. For the purpose of section (1):

(a) "Intentionally" means the employer or insurer acted with a conscious objective to cause any result described in ORS

656.745(1) or to engage in the conduct described in that section; and

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

(3) Under ORS 656.745, the director may assess a civil penalty against an employer or insurer that does not comply with rules and orders of the director regarding reports or other requirements necessary to carry out the purposes of the Workers' Compensation Law. Except as provided in ORS 656.780, the director may assess a civil penalty against a service company only for claims processing violations identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an employer, insurer, or service company identified in an annual audit.

(4) The director may assess a civil penalty up to $2,000 to an employer or insurer that does not meet the time frame requirements in OAR 436-060-0010, 436-060-0017, 436-060-0018, 436-060-0030, 436-060-0060, 436-060-0147, 436-060-0155 and 436-060-0180. The director may assess a civil penalty up to $2,000 to a service company failing to meet the time frame requirements, only for violations identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an employer, insurer, or service company identified in an annual audit.

(5) An insurer that willfully violates OAR 436-060-0160 will be assessed a civil penalty of up to $2,000.

(6) An insurer that does not accurately report timeliness of first payment information to the division may be assessed a civil penalty by the director of $500 for reporting inaccurate information plus $50 for each violation, or $10,000 in the aggregate for all violations within any three month period. The director may assess this civil penalty to the service company processing the insurer's claims if the violations were identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an insurer or service company identified in an annual audit. For the purposes of this section, a violation consists of each situation where a first payment was reported to have been made timely, but was found upon audit to have actually been late.

(7) Notwithstanding section (3) of this rule, an employer, insurer, or service company that does not comply with the claims processing requirements of ORS chapter 656, and rules and orders of the director 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.

(8) Any employer or insurer that misrepresents themselves in any manner to obtain workers' compensation claims records from the director, or that uses such records in a manner contrary to these rules, is subject to a civil penalty of $1,000 for each occurrence. In addition, the director may suspend or revoke an employer's or insurer's access to workers' compensation claims records for such time as the director may determine. Any other person determined to have misrepresented themselves or who uses records in a manner contrary to these rules will have access to these records suspended or revoked for such time as the director may determine.

(9) For the purpose of section (7), statutory claims processing requirements include but are not limited to, ORS 656.202, 656.210, 656.212, 656.228, 656.234, 656.236, 656.245, 656.262, 656.263, 656.264, 656.265, 656.268, 656.273, 656.307, 656.313, 656.325, 656.331, and 656.335.

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

(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 outlined in this section.

(11) Insurer performance data is reviewed every quarter based on reports submitted by the insurer during the previous calendar quarter. Civil penalties will be issued for each of the performance areas where the percentages fall below the acceptable standards of performance as set forth in these rules. The standard for reporting claims to the division will allow insurers to report claims by filing a Form 1502 accompanied by a Form 827 where the Form 801 is not available. Penalties will be issued in accordance with the matrix set forth in Appendix "C."

(12) Under ORS 656.262(14), an injured worker's attorney that is not willing or available to participate in an interview at a time reasonably chosen by the insurer within 14 days of the request for interview may be assessed a civil penalty not to exceed $1,000 if the director finds the attorney's actions unreasonable.

Stat. Auth.: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.202, 656.210, 656.212, 656.228, 656.234, 656.236, 656.245, 656.262 (Oregon Laws 2009, ch. 526), 656.263, 656.264, 656.265, 656.268, 656.273, 656.307, 656.313, 656.325, 656.331, 656.335, 656.704, 656.726(4), and 656.745
Hist.: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0400 Penalty and Attorney Fee for Untimely Payment of Disputed Claims Settlement

(1) If the insurer fails to pay amounts due on a disputed claims settlement within five business days of receipt of notice from the worker that the payment is late, the worker or worker's attorney may request penalties and attorney fees.

(2) Requests for penalties and attorney fees under this section must be in writing, state what payments were delayed or remain unpaid, and mailed or delivered to the division within 180 days of the date of notice to the insurer. In order to be awarded an attorney fee the attorney must submit a signed, current retainer agreement.

(3) When notified by the director that a penalty or attorney fees have been requested under this rule, the insurer must respond in writing to the division. The response must be

mailed or delivered to the division within 14 days of the date of the division's inquiry letter, with copies of the response, including any attachments, sent simultaneously to the worker and the worker's attorney (if represented). If an insurer fails to respond, provides an inadequate response (e.g. fails to answer specific questions or provide requested documents), or fails to timely provide copies of the response to the worker or attorney, civil penalties may be assessed under OAR 436-060-0200.

(4) The penalty and fee will be based on the amounts allocated to the worker and the attorney in the settlement agreement as prescribed in ORS 656.262(12)(b). Penalties will be issued in accordance with the matrix set forth in Appendix "D."

(5) Penalties and attorney fees ordered under this rule must be paid to the worker and attorney no later than the 30th day after the date of the order, unless the order is appealed. If the order is appealed and later upheld, the penalty and attorney fee will be due within 14 days of the date the order upholding the penalty becomes final. Failure to pay penalties and attorney fees in a timely manner will subject the insurer to civil penalties under OAR 436-060-0200.

Stat. Auth.: ORS 656.726(4)
Stat. Impltd: ORS 656.262 (Oregon Laws 2009, ch. 526)
Hist.: Adopted 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

436-060-0500 Reimbursement of Supplemental Disability for Workers with Multiple Jobs at the Time of Injury

(1) When an insurer elects to pay supplemental disability due a worker with multiple jobs at the time of injury, the director shall pay reimbursement of the supplemental amount quarterly, after receipt and approval of documentation of compensation paid by the insurer or the service company. The director will reimburse the insurer, in care of a service company, if applicable.

(2) Requests for reimbursement must be submitted on Form 3504, "Supplemental Disability Benefits Quarterly Reimbursement Request," and must include at least:

(a) Identification and address of the insurer responsible for processing the claim;

(b) The worker's name, WCD file number, date of injury, social security number, and the insurer claim number;

(c) Whether the claim is disabling or nondisabling;

(d) The primary and secondary employer's legal names;

(e) The primary and secondary employer's WCD registration numbers;

(f) The weekly wage of all jobs at the time of the injury separated by employer;

(g) The dates for the period(s) of supplemental disability due and payable to the worker. Dates must be inclusive (e.g., 1-16-02 through 1-26-02);

(h) The amount of supplemental disability paid for the periods in (2)(g);

(i) The quarter and year in which the payment was made;

(j) A signed payment certification statement verifying the payments; and

(k) Any other information the director requires.

(3) In addition to the supplemental disability reimbursement, the division shall calculate and the insurer shall be paid an administrative fee based on the annual claim processing administrative cost factor, as published in Bulletin 316.

(4) Periodically the division will audit the physical file of the insurer responsible for processing the claim to validate the amount reimbursed. Reimbursement will be disallowed and repayment will be required if, upon such audit, it is found:

(a) Payments exceeded statutory amounts due, excluding reasonable overpayments, as determined by the division;

(b) Compensation has been paid as a result of untimely or inaccurate claims processing; or

(c) Payments of compensation have not been documented, as required by OAR 436-050.

(5) Supplemental disability benefits due subject workers of an employer who is in a noncomplying status as defined in ORS 656.052 are not eligible for separate reimbursement under this rule, but remain a cost recoverable from the employer as provided by ORS 656.054(2).

(6) Claim Dispositions or Stipulated Settlements, under ORS 656.236 or 656.289 which include amounts for supplemental disability benefits due to multiple jobs, are not eligible to receive reimbursement from the Workers' Benefit Fund unless made with the prior written approval of the director.

(a) Requests for written approval of proposed dispositions must include:

(A) A copy of the proposed disposition or settlement that specifies the amount of the proposed contribution to be made from the Workers' Benefit Fund;

(B) A statement from the insurer indicating how the amount of the contribution was calculated; and

(C) Any other information required by the director.

(b) The director will not approve the disposition for reimbursement if the proposed contribution exceeds a reasonable projection of that claim's future liability to the Workers' Benefit Fund.

Statutory authority: ORS 656.704, 656.726(4)
Statutes implemented: ORS656.210, 656.704, and 656.726(4)
Hist.: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0510 Reimbursement of Permanent Total Disability Benefits from the Workers' Benefit Fund

(1) The insurer may request reimbursement of permanent total disability benefits paid after the date of the notice of closure under ORS 656.206(6)(a).

(2) Requests for reimbursement must be filed within one year of the mailing date of the final order upholding the notice of closure and include:

(a) Sufficient information to identify the insurer and the injured worker;

(b) The net dollar amount of permanent total disability benefits paid ("Net dollar amount" means the total compensation paid less any recoveries, including, but not limited to, third party recovery or amounts reimbursable from the Retroactive Program or Reopened Claims Program.); and

(c) A statement certifying that payment has been made.

(3) If any of the monies are due under the Retroactive Program or Reopened Claims Program, any reimbursement request must be submitted under OAR 436-075 or OAR 436-045, respectively.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.206, 656.605
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

APPENDIX "A"
436-060-0017 Matrix for Assessing Penalties

VIOLATION NUMBER

Number of days late	1	2	3	4	5+
1-7	$0	$100	$250	$500	$1,000
8-14	$100	$250	$500	$1,000	$1,000
15-21	$250	$500	$1,000	$1,000	$1,000
22+	$500	$1,000	$1,000	$1,000	$1,000

APPENDIX "B"
436-060-0155 Matrix for Assessing Penalties

VIOLATION NUMBER

Number of days late	1	2	3	4
1-2	0%	10%	20%	25%
3-7	5%	15%	25%	
8-14	10%	20%	25%	
15-21	15%	25%		
22 +	25%			

APPENDIX "C"
436-060-0200 Matrix for Assessing Penalties
Number of Quarters Below Standard

Performance Level Per Year

Category	1	2	3	4
Timely Filing of Claim (Form 1502)	$100 each violation	$175 each violation	$250 each violation	$350 each violation
Notice of Closure Issued Timely	$100 each violation	$175 each violation	$250 each violation	$350 each violation
Accept/Deny Timely	$100 each violation	$175 each violation	$350 each violation	$700 each violation
1st Payment Timely	$100 each violation	$175 each violation	$350 each violation	$700 each violation

APPENDIX "D"
436-060-0400 Matrix for Assessing Penalties

SETTLEMENT PROCEEDS ALLOCATED TO CLAIMANT/ATTORNEY

NUMBER OF DAYS LATE	**PENALTY ASSESSMENTS AND ATTORNEY FEES**
1-2	5%
3-7	10%
8-14	15%
15-30	20%
31+	25%

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 070

WORKERS' BENEFIT FUND ASSESSMENT

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436-070-0001 Authority for Rules

(1) These rules are adopted under the director's authority contained in ORS 656.726 and 656.506.

Stat. Auth.: ORS 656.726, 656.506
Stats. Implemented: ORS 656.506
Hist.: Amended 3/23/05 as WCD Admin. Order 05-053, eff. 4/1/05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-070-0002 Purpose

The purpose of these rules is to:

(1) Prescribe the rate of the Workers' Benefit Fund assessment under ORS 656.506;

(2) Prescribe the manner and intervals in which the assessment rate is to be calculated;

(3) Prescribe the manner and intervals employers are to withhold, file, and remit assessments; and

(4) Prescribe the conditions affecting the adjustment of the assessments as authorized by ORS 656.506.

Stat. Auth.: ORS 656.506, 656.726(4)
Stats. Implemented: ORS 656.506
Hist.: Amended 12/7/12 as WCD Admin. Order 12-063, eff. 4/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-070-0003 Applicability of Rules

(1) These rules are effective April 1, 2013.

(2) These rules govern the Workers' Benefit Fund assessment under ORS 656.506.

(3) These rules apply to all subject employers as defined in ORS 656.005 and any otherwise non-subject employer who elects coverage pursuant to ORS 656.039.

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

Stat. Auth.: ORS 656.506, 656.726(4)
Stats. Implemented: ORS 656.506
Hist.: Amended 12/7/12 as WCD Admin. Order 12-063, eff. 4/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-070-0005 Definitions

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

(1) "Assessments" means the funds due from employees and employers pursuant to ORS 656.506.

(2) "Employee" means a subject Oregon worker as defined in ORS 656.005 and any otherwise nonsubject worker for whom coverage is elected under ORS 656.039.

(3) "Fund" means the Workers' Benefit Fund as created in ORS 656.506.

(4) "Fund balance" means the balance of the fund after revenue and investment income has been added and expenditures have been subtracted.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.506
Hist.: Amended 3/23/05 as WCD Admin. Order 05-053, eff. 4/1/05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-070-0008 Administrative Review

(1) Contested case hearings regarding sanctions and civil penalties: Any employer as defined by ORS 656.005 aggrieved by a proposed order or proposed assessment of civil penalty of the director issued pursuant to ORS 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with 656.740.

(a) The request for hearing must be sent in writing to the administrator of the Workers' Compensation Division. No hearing will be granted unless the request specifies the grounds upon which the person requesting the hearing contests the proposed order or assessment.

(b) The request for hearing must be filed with the administrator of the Workers' Compensation Division within 60 days after the mailing of the proposed order or assessment. No hearing will be granted unless the request is mailed or delivered to the administrator within 60 days after the mailing date of the proposed order or assessment.

(2) Hearings regarding estimation actions and orders: Under ORS 656.704(2), any employer who disagrees with an action or order of the director under these rules, other than as described in section (1), may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 656.735 and 656.740
Stats. Implemented: ORS 656.704, OL 2005 ch 26, 656.735, 656.740
Hist.: Amended 10/19/05 as WCD Admin. Order 05-064, eff. 1/2/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-070-0010 Assessment Rate: Method and Manner of Determining

(1) All subject employers and any employer electing to provide workers' compensation coverage for its employees must pay an assessment rate of 3.3 cents per hour to the Department of Consumer and Business Services, under this rule division and ORS 656.506.

(2) Factors considered in developing the rate include, but are not limited to:

(a) The estimated annual fund expenditures and revenues;

(b) The fund balance requirements;

(c) The estimated annual hours worked per employee;

(d) The estimated number of employees covered by workers' compensation insurance; and

(e) Other records relating to fund expenditures and revenues.

Stat. Auth.: ORS 656.506, 656.726(4)
Stats. Implemented: ORS 656.506
Hist.: Amended 12/7/12 as WCD Admin. Order 12-063, eff. 4/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-070-0020 Assessments: Manner and Intervals for Payment

(1) Every employer must compute the total assessment amount due for each employee by multiplying the assessment rate determined in OAR 436-070-0010 by the number of hours or parts of an hour the employee worked in the pay period.

(a) If actual hours worked are not tracked, an employer may either calculate the assessments using a flat rate, use contract information stating the number of hours an employee works, or come up with a reasonable method for calculating hours worked. If the flat rate method is used, the calculation must be based on 40 hours per week for employees paid weekly or biweekly, or 173.33 hours per month for employees paid monthly or semi-monthly.

(b) The employer will retain from the moneys earned by each employee one half (1/2) of the amount due. In addition, the employer will be assessed an amount equal to the amount retained from each employee.

(2) Every employer must file a report of employee hours worked and remit amounts due upon a combined tax and assessment report form prescribed by the Department of Revenue. The report must be filed with the Department of Revenue:

(a) At the times and in the manner prescribed in ORS 316.168 and 316.171; or

(b) Annually as required or allowed pursuant to ORS 316.197 or 657.571.

(3) For employers required to report quarterly, reports and payments are due on or before the last day of the first month after the close of each calendar quarter. For employers that report annually, reports and payments are due on or before the last day of January following the close of each calendar year.

(4) Employers who fail to timely and accurately file and remit assessments may be charged interest on all overdue balances at the rate established by ORS 82.010 and may be assessed civil penalties in accordance with OAR 436-070-0050.

(5)(a) If an employer fails to file a report or the director determines, based on the available data, that the report filed understates assessments, the director may send to the employer a written Failure to File Notice or Notice of Audit Findings. The notice will include a warning that failure to timely and accurately resolve all issues addressed in the written notice may result in the imposition of a civil penalty. The director may coordinate with the Department of Revenue and Employment Department to provide written notice of failure to file.

(b) Within 30 days of the Failure to File Notice or the Notice of Audit Findings, the employer must file an accurate report and remit the assessments due, or otherwise resolve to the satisfaction of the director all issues identified in the written notice. If an employer fails to comply with the notice, the director may estimate the assessments due, including penalties and interest, and send to the employer a Notice of Estimation.

(c) Within 30 days of the Notice of Estimation, the employer must pay the director's estimated assessment or file and remit accurate assessment due. If the employer fails to comply with the notice, the director may send to the employer an Order of Default assessing all amounts due as calculated by the director.

(d) Within 30 days of the Order of Default, the employer must remit the estimated assessment due, unless the order is timely appealed as provided in OAR 436-070-0008.

(6) Employers or the director may initiate activity to resolve reporting errors, omissions, or discrepancies for a period not to exceed the current calendar year plus three prior calendar years. No calendar year limitation applies to cases involving fraud.

(7) When the director determines that the department has received moneys in excess of the amount legally due and payable or that it has received moneys to which it has no legal interest, the director will refund or credit the excess amount. For amounts less than $20, the director will refund to employers the excess amount only upon receipt of a written request from the employer or the employer's legal representative.

Stat. Auth.: ORS 656.506 and 82.010
Stats. Implemented: ORS 656.506 and 293.445
Hist.: Amended 6/15/06 as WCD Admin. Order 06-057, eff. 7/1/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-070-0040 Monitoring/Auditing

(1) Employers must maintain payroll and employment records which reflect the total hours worked by all employees for the current calendar year plus three prior calendar years.

(2) Pursuant to ORS 656.726, the director may inspect the books, records and payrolls of employers pertinent to the administration of these rules. Employers must provide the director with all pertinent books, records and payrolls upon request.

Stat. Auth.: ORS 656.726(8) and 656.758
Hist.: Amended 3/23/05 as WCD Admin. Order 05-053, eff. 4/1/05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-070-0050 Assessment of Civil Penalties

(1) The director pursuant to ORS 656.745 may assess a civil penalty against an employer.

(2) If the director finds any employer in violation of OAR 436-070 or an order of the director, the employer may be subject to penalties pursuant to ORS 656.745 of not more than $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, will be considered a separate violation.

(3) An employer may be assessed a penalty for late filing or payment when received more than 10 calendar days after the due date established in OAR 436-070-0020(2). The penalty will be assessed at 10% of the outstanding balance, with a minimum of $50 for each violation up to $2,000. Penalties are in addition to interest and assessments owed.

Stat. Auth.: ORS 656.745(2)
Hist.: Amended 3/23/05 as WCD Admin. Order 05-053, eff. 4/1/05
See also the Index to Rule History: http://wcd.oregon.gov/policy/rules/history.html.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 075

RETROACTIVE PROGRAM

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436-075-0001 Authority for Rules

These rules are promulgated under the director's authority in ORS 656.726 and 656.506.

Stat. Auth.: ORS 656.506 and ORS 656.726
Stats. Implemented: ORS 656.506
Hist.: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0002 Purpose

The purpose of these rules is to establish guidelines for administering disbursements made from the Retroactive Program.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.506
Hist.: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0003 Applicability of Rules

(1) These rules are effective January 1, 2016, and apply to all requests for reimbursement from the Retroactive Program involving benefits payable under:

(a) ORS 656.204 Death

(b) ORS 656.206 Permanent Total Disability

(c) ORS 656.208 Death During Permanent Total Disability

(d) ORS 656.210 Temporary Total Disability for injuries before April 1, 1974.

(2)The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.209, ORS 656.206, ORS 656.208, ORS 656.210, ORS 656.236, ORS 656.289 and ORS 656.506
Stats. Implemented: ORS 656.204, ORS 656.206, ORS 656.208, ORS 656.210, ORS 656.276, ORS 656.289 and ORS 656.506
Hist.: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0005 Definitions

Except where the context requires otherwise, these rules are governed by the following definitions:

(1) "Beneficiaries" are those persons as defined in ORS 656.005.

(2) "Child" is as defined in the laws applicable at the worker's date of injury.

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

(4) "Director" means the director of the Department of Consumer and Business Services or the director's designee.

(5) "Disposition" or "claim disposition" means the written agreement executed by all parties in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794, except for medical services, in an accepted claim.

(6) "Insurer" means the State Accident Insurance Fund Corporation, an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state, or an employer or employer group that has been certified as self-insured under ORS 656.430.

(7) "Performance Section" means the Performance Section of the Workers' Compensation Division of the Department of Consumer and Business Services.

(8) "Retroactive Program benefit" means that additional benefit paid to eligible claimants or beneficiaries to bring their benefits to a more current level.

(9) "Social Security offset" means a reduction of permanent total disability benefits or fatal benefits based on the amount of federal social security disability benefits received by a worker or surviving spouse.

(10) "Spouse" means the spouse of a worker. This definition includes cohabitants under ORS 656.226.

(11) "Statutory benefit" means any benefit payable to or on behalf of the injured worker under the law in effect at the time of the worker's injury, as modified by marital and dependency status changes.

(12) "Through" means inclusion of a specific date.

(13) "To" means until but not including a specific date.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.726
Hist.: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0006 Administration of Rules

In administering these rules, orders of the Performance Section are deemed orders of the director.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.726
Hist.: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0008 Administrative Review

(1) Any party as defined by ORS 656.005 aggrieved by a proposed order or proposed assessment of civil penalty of the director or division issued under ORS 656.745 or 656.750 may

request a hearing by the Hearings Division of the Workers' Compensation Board under ORS 656.740.

(a)The request for hearing must be sent in writing to the Administrator of the Workers' Compensation Division. No hearing will be granted unless the request specifies the grounds on which the person requesting the hearing contests the proposed order or assessment.

(b)The request for hearing must be filed with the Administrator of the Workers' Compensation Division by the aggrieved person within 60 days after the mailing of the proposed order or assessment. No hearing will be granted unless the request is mailed or delivered to the administrator within 60 days after the mailing date of the proposed order or assessment.

(2) Under ORS 656.704(2), any party that disagrees with an action or order of the director under these rules, other than as described in section (1), may request a hearing by filing a request for hearing under OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 656.740, 656.745, 656.750
Stats. Implemented: ORS 656.704, OL 2005 ch 26, 656.740, 656.745, 656.750
Hist.: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0010 Criteria for Eligibility

(1) The department will issue a bulletin to notify all insurers of changes in the Retroactive Program benefit levels whenever the director determines a change is necessary under ORS 656.506(7).

(2) Eligibility for Retroactive Program benefits is based on the worker's injury date as follows:

(a) Workers or beneficiaries eligible to receive either death or permanent total disability benefits become eligible for Retroactive Program benefit increases when the benefits granted under the Retroactive Program bulletin exceed the benefits provided by the statute in effect at the time of the injury.

(b) For workers receiving temporary total disability benefits, the injury must have occurred before July 1, l973. Workers with injuries occurring between July 1, 1973 and April 1, 1974 may qualify for benefits according to the limits defined in the Retroactive Program bulletin. Workers injured on or after April 1, 1974 are not entitled to receive Retroactive Program increases to their temporary total disability benefit.

(3) A claim is not eligible for Retroactive Program benefits if all issues except compensable medical services are disposed of under ORS 656.236 or settled under ORS 656.289 before becoming eligible under section (2) of this rule.

(4) Costs for claims of subject workers of a noncomplying employer under ORS 656.052 are not eligible for reimbursement from the program, but remain a cost recoverable from the employer under ORS 656.054(3).

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.236, ORS 656.289 and ORS 656.506
Hist.: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0020 Death Benefit

(1) Death benefits must be paid to eligible beneficiaries under ORS 656.204 and the Retroactive Program benefit schedules.

(2) Burial benefits must be paid under ORS 656.204 (1) and the Retroactive Program benefit schedules.

(3) The statutory death benefit for injuries occurring from July 1, 1973 to April 1, 1974 will be reduced by the Social Security benefit received, up to the July 1, 1973 statutory benefit level. The amount of reduction to the statutory benefit is a Retroactive Program benefit. The insurer may request reimbursement only for the adjusted Retroactive Program benefit.

(4) Benefits payable for a partial month must be calculated by dividing the monthly benefit by the actual number of days in the month and multiplying that result by the number of days payable.

(5) Benefits for beneficiaries must be paid to the date of any status change.

(6) Remarriage allowance must be paid under ORS 656.204 and the Retroactive Program benefit schedules.

(7) At least once every two years, the insurer must verify that all beneficiaries receiving death benefits for which the insurer may request reimbursement from the Retroactive Program are alive and remain eligible for those benefits. Insurers' questions regarding beneficiaries' status must be reasonably pertinent to the continuing eligibility of those persons for benefits.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.204
Hist.: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0030 Permanent Total Disability Benefit

(1) Permanent total disability benefits must be paid under ORS 656.206 and the benefit schedules in the Retroactive Program bulletin.

(2) Benefit amounts payable for a partial month must be calculated under 436-075-0020(4).

(3) Benefits for beneficiaries must be paid to the date of any status change.

(4) Any Social Security offset determined under ORS 656.209 must first be applied against the statutory portion of the permanent total disability benefit. Any amount of the Social Security offset that exceeds the statutory benefit must be applied against the Retroactive Program benefit. The insurer may request reimbursement only for that portion of the Retroactive Program benefit that has not been offset.

(5) At least once every two years, the insurer must verify that all beneficiaries receiving benefits for which the insurer may request reimbursement from the Retroactive Program are alive and remain eligible for those benefits. Such "status checks" of beneficiaries may occur at the same time the insurer reexamines the permanent total disability claim under OAR 436-030-0065(1). Insurers' questions regarding beneficiaries' status must be reasonably pertinent to the continuing eligibility of those persons for benefits.

Stat. Auth.: ORS 656.506

Stats. Implemented: ORS 656.206 and ORS 656.209
Hist.: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0040 Death during Permanent Total Disability

(1) If the injured worker dies during the period of permanent total disability, death benefits must be paid to eligible beneficiaries under ORS 656.208,656.204, and the Retroactive Program benefit schedules.

(2) Permanent total disability benefits must be paid to the date of death, at which time death benefits will begin. Where death benefits are not due, permanent total disability benefits must be paid through the date of death.

(3) The Social Security benefit for injuries occurring between July 1, 1973 and April 1, 1974 must be applied under OAR 436-075-0020 (3).

(4) Benefit amounts payable for a partial month must be calculated under OAR 436-075-0020(4).

(5) Burial benefits must be paid under ORS 656.208 (1), 656.204 (1), and the Retroactive Program benefit schedules. However, if the injury date is before July 1, 1973, burial benefits are due only if death results from the accidental injury causing the permanent total disability.

(6) At least once every two years, the insurer must verify that all beneficiaries receiving death benefits for which the insurer may request reimbursement from the Retroactive Program are alive and remain eligible for those benefits. Insurers' questions regarding beneficiaries' status must be reasonably pertinent to the continuing eligibility of those persons for benefits.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.204 and ORS 656.208
Hist.: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0050 Temporary Total Disability

(1) Temporary total disability benefits must be paid under ORS 656.210, OAR 436-060-0150, and the benefit schedules in the Retroactive Program bulletin.

(2) The computation of benefits under these rules and the Retroactive Program bulletin may not reduce temporary total disability benefits currently being paid.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.210
Hist.: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0065 Dispositions

(1) Disposition of the claim by the parties under ORS 656.236, or settlement of the claim under ORS 656.289, is not eligible for reimbursement from the Retroactive Program unless made with the director's prior written approval.

(2) Requests for written approval of proposed dispositions must include:

(a) A copy of the proposed disposition that specifies the amount of the proposed contribution to be made from the Retroactive Program;

(b) A statement from the insurer indicating how the amount of the contribution was calculated; and

(c) Any other information required by the director.

(3) The director will not approve the disposition for reimbursement if:

(a) The ratio of the amount requested from the program to the total amount of the disposition exceeds the percentage of current benefits due the worker from the program; or

(b) The settlement exceeds a reasonable projection of future liability.

(4) The insurer must submit dispositions to the division in the format prescribed by the director.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.236 and ORS 656.289
Hist.: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0070 Reimbursement

(1) Reimbursement from the Retroactive Program will be authorized by the Performance Section on a quarterly basis.

(2) Requests for reimbursement must be mailed or delivered to the Performance Section within 30 days after the end of each quarter to be processed in that quarterly disbursement.

(3) Requests for reimbursement mailed or delivered to the Performance Section more than 30 days after the end of the quarter will be processed with the next quarterly disbursement.

(4) A separate request for reimbursement must be submitted for each insurer and include a signed certification that the payments reported on the request have been made in the amounts reported.

(5) Requests for reimbursement must be submitted in the format prescribed by the director. Each request must accurately reflect the marital and dependency status in effect and eligible for reimbursement in the period requested.

(6) The Performance Section will not process any request that does not meet the requirements of section (4) or (5) of this rule until such requirements are met.

(7) The department will recover any overpayment made to an insurer as a result of an insurer error in reporting, or incorrect information submitted, on a quarterly request form.

(8) If a denied claim is found to be compensable by an administrative law judge, the Workers' Compensation Board, or the Court of Appeals, and that decision is reversed by a higher level of appeal, the insurer will receive reimbursement for Retroactive Program benefit payments required to be made while the claim was in an accepted status.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.506
Hist.: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0090 Third Party Recovery

(1) In a third party recovery, previously reimbursed Retroactive Program benefits are a portion of the paying agency's lien.

(2) Under ORS 656.593, when the insurer learns of third party settlement negotiations on any claim for which it has received reimbursement from the Retroactive Program, the insurer must notify the Performance Section.

(3) Remittance on recovered Retroactive Program benefits must be made to the department in the quarter following the recovery in amounts determined under ORS 656.591 and 656.593.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.591 and ORS 656.593
Hist.: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0100 Assessment of Civil Penalties

Under ORS 656.745 the director may assess a civil penalty against an insurer for failure to comply with these rules. Penalty orders will be issued under ORS 656.447 and 656.704 and are subject to review under OAR 436-075-0008.

Stat. Auth.: ORS 656.745
Stats. Implemented: ORS 656.204, ORS 656.726, ORS 656.745 and ORS 656.447
Hist.: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 080

NONCOMPLYING EMPLOYERS

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436-080-0001 Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.726 and 656.054.

Stat. Auth.: ORS 656.054, ORS 656.726
Stats. Implemented: ORS 656.726
Hist.: Amended 12/3/03 as WCD Admin Order 03-065, eff. 1/1/04
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-080-0002 Purpose

It is the purpose of the director that under ORS 656.726(4) and ORS 656.054 rules be established to ensure the requirements of ORS 656.017 are met. To meet that responsibility the director has delegated to the division the responsibility of ensuring the requirements of the statutes, rules, and bulletins of the department are complied with as they relate to employer coverage.

Stat. Auth.: ORS 656.054, ORS 656.726
Stats. Implemented: ORS 656.726
Hist.: Amended 12/3/03 as WCD Admin Order 03-065, eff. 1/1/04
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-080-0003 Applicability of Rules

These rules are effective January 1, 2004 and carry out the provisions of:

(1) ORS 656.017 - Employer required to pay compensation and perform other obligations and duties.

(2) ORS 656.052 - Prohibition against employment without coverage; proposed order declaring noncomplying employer; effect of failure to comply.

(3) ORS 656.054 - Claim of injured worker of noncomplying employers; notice of proposed penalty; recovery of costs from noncomplying employer.

(4) ORS 656.735 - Civil penalty for noncomplying employers; amount; liability of corporate officers; effect of final order; penalty as preferred claim; disposition of moneys collected.

(5) ORS 656.740 - Review of proposed order declaring noncomplying employer, proposed assessment or civil penalty; insurer as party; hearing.

Stat. Auth.: ORS 656.054, ORS 656.726
Stats. Implemented: ORS 656.726
Hist.: Amended 12/3/03 as WCD Admin Order 03-065, eff. 1/1/04
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-080-0005 Definitions

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

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

(2) "Director" means the director of the Department of Consumer and Business Services or the director's delegate.

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

(4) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

Stat. Auth.: ORS 656,054, ORS 656.726
Stats. Implemented: ORS 656.726
Hist.: Amended 12/3/03 as WCD Admin Order 03-065, eff. 1/1/04
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-080-0006 Administration of Rules

Any order issued by the division in carrying out the director's authority to enforce ORS chapter 656 and the rules adopted pursuant thereto is considered an order of the director.

Stat. Auth.: ORS 656.054, ORS 656.726
Stats. Implemented: ORS 656.052, ORS 656.054, ORS 656.726
Hist.: Amended 12/3/03 as WCD Admin Order 03-065, eff. 1/1/04
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-080-0010 Initiation of Proceedings; Issuance of Noncomplying Employer Order

If an employer has failed to comply with ORS 656.017, the division will investigate. If the division finds the employer is a subject employer that has failed to file proof of qualification in the manner required by ORS 656.407, as either a carrier-insured employer or a self-insured employer, the division will issue a Proposed and Final Order declaring the employer to be a noncomplying employer, and assess a civil penalty pursuant to ORS 656.735(1) for violation of ORS 656.052.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.017, ORS 656.052, ORS 656.735
Hist.: Amended 12/3/03 as WCD Admin Order 03-065, eff. 1/1/04
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-080-0020 When a Hearing on the Order Is Not Requested

If the employer does not request a hearing on the order within the 60 days allowed by ORS 656.740, the division may request the Department of Justice to commence proceedings to enjoin the employer under ORS 656.052(3).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.052, ORS 656.735, ORS 656.740
Hist.: Amended 12/3/03 as WCD Admin Order 03-065, eff. 1/1/04
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-080-0030 When a Hearing on the Order Is Requested

(1) A request for hearing on an order issued under OAR 436-080-0010 or 436-080-0040 must specify the grounds upon which the employer contests the order and must be mailed or delivered to the division within 60 calendar days after the mailing of the order.

(2) When a person who is served with an order timely files a request for a hearing, the division will forward the request and other pertinent information to the Hearings Division.

(3) A division officer or employee is authorized to appear (but not make legal argument) on behalf of the director in a hearing or in a class of hearings in which the Attorney General or the Deputy Attorney General has given written consent for such representation. A copy of the list of contested case hearings for which the Attorney General or the Deputy Attorney General has given consent is maintained by the division and the Department of Justice.

(4) "Legal argument" as used in ORS 183.452 and this rule has the same meaning as in the Attorney General's Model Rule of Procedure 137-003-0008 (1) (c) and (d), which is hereby adopted by reference.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.052, ORS 656.735, ORS 656.740
Hist.: Amended 12/3/03 as WCD Admin Order 03-065, eff. 1/1/04
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-080-0040 Assessment of Civil Penalties Against Non-complying Employer; Hearing on Proposed Assessment

(1) In accordance with ORS 656.735(1), the amount of penalty for a person's first violation of ORS 656.052(1) shall be the greater of $1,000 or twice the premium the employer would have paid during the non-complying period if insurance had been provided.

(a) The division may reduce the amount of the penalty due, to 105% of the amount of premium the employer would have paid during the noncomplying period if insurance had been provided if, prior to the penalty order becoming final, the employer:

(A) Agrees to not contest the penalty order;

(B) Provides evidence satisfactory to the division that it is no longer a subject employer or, if it is still a subject employer, that it has now complied with ORS 656.052(1);

(C) Provides adequate payroll information to enable the division to calculate the amount of premium the employer would have paid during the noncomplying period if insurance had been provided; and

(D) Makes arrangements satisfactory to the division for prompt payment of the reduced penalty amount.

(b) If 105% of the amount of premium the employer would have paid during the noncomplying period is less than $500, the reduced penalty will be $500.

(2) The amount of penalty, when assessed against the employer pursuant to ORS 656.735(2), shall be $250 per day for each calendar day the employer has continued to violate ORS 656.052(1), commencing with the first day of such violation:

(a) The division may reduce the amount of the penalty due to 150% of the amount of premium the employer would have paid during the non-complying period if insurance had been provided if, prior to the penalty order becoming final, the employer:

(A) Agrees to not contest the penalty order;

(B) Provides evidence satisfactory to the division that it is no longer a subject employer or, if it is still a subject employer, that is has now complied with ORS 656.052(1);

(C) Provides adequate payroll information to enable the division to calculate the amount of premium the employer would have paid during the noncomplying period if insurance had been provided; and

(D) Makes arrangements satisfactory to the division for prompt payment of the reduced penalty amount.

(b) If 150% of the amount of premium the employer would have paid during the noncomplying period is equal to or greater than $250 per calendar day of noncompliance, there will be no reduction of the penalty amount.

(c) If 150% of the amount of premium the employer would have paid during the noncomplying period is less than $1000, the reduced penalty will be $1000.

(3) For the purpose of this rule, "premium the employer would have paid during the noncomplying period" means:

(a) If payroll records are available, actual premium using the applicable occupational base rate premium applied to the payroll of the employer during the period of noncompliance; or

(b) If payroll records are not available, estimated premium based upon the number of workers employed during the noncomplying period times the average weekly wage as defined in ORS 656.005(1), using the applicable assigned risk base rated premium during the period of noncompliance.

(4) The division will mail or otherwise serve an order assessing a civil penalty, with a notice to the employer of rights under ORS 656.740.

(5) When a penalty order becomes final, the division will transfer the matter to Fiscal and Business Services of the department to collect the penalty.

Stat. Auth.:ORS 656.052, ORS 656.726, ORS 656.735
Stats. Implemented: ORS 656.052, ORS 656.735, ORS 656.740
Hist.: Amended 12/3/03 as WCD Admin Order 03-065, eff. 1/1/04
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-080-0060 When a Worker Files a Claim for an Injury

(1) When the division issues an order under OAR 436-080-0010 declaring an employer a noncomplying employer, and a subject worker has filed a claim for an injury sustained during the period of noncompliance while the worker was employed by such employer, the division will:

(a) Refer the claim with a copy of the order and the results of its investigation to the assigned claims agent for processing as required by ORS 656.054; and

(b) Inform the worker, the worker's representative, if represented, and the employer that the claim has been referred to the assigned claims agent;

(2) The notice to the employer will inform the employer of the right to object to the claim.

(3) If the employer wishes to object to the claim, the employer shall request a hearing. The request for hearing must be filed within 60 days from the date of the mailing of the Notice of Referral.

(4) When the assigned claims agent accepts or denies the claim, it shall notify the worker, employer, and the division of its action within the time provided by ORS 656.262.

(5) When the division finds that at the time of the injury, either the worker was not a subject worker or the employer was not a subject employer, the worker and employer shall be notified of such determination. The worker may request a hearing by filing a hearing request within 60 days after the mailing of the determination. The hearing request must be sent to the Workers' Compensation Division administrator. The worker and employer shall be parties to any such hearing, and will be notified by the Hearings Division of the time and place set for hearing.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.054,
Hist.: Amended 12/3/03 as WCD Admin Order 03-065, eff. 1/1/04
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-080-0065 Determination Of Assigned Claims Agent

(1) When selecting an assigned claims agent, the director will consider claims processing performance data collected by the division. That data and data provided by potential assigned claims agents will be used to determine which claims agent can deliver the most timely and appropriate benefits to injured workers and can best control claim costs and administrative costs. In addition, the director may use any other factors the director considers appropriate.

(2) If no qualified entity agrees to be an assigned claims agent, the director may require one or more of the three highest premium producing insurers to be assigned claims agents. In addition to the premium consideration, the criteria described in section (1) of this rule will be used to make that determination.

Stat. Auth.: ORS 656.054, ORS 656.726
Stats. Implemented: ORS 656.054
Hist.: Amended 12/3/03 as WCD Admin Order 03-065, eff. 1/1/04
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-080-0070 Reimbursement of Assigned Claims Agent for Claims Costs for Injured Workers of Noncomplying Employers

(1) When an assigned claims agent pays compensation to a claimant or incurs other costs on a claim referred to it under ORS 656.054, the assigned claims agent shall report the payment to the department as established by contract with the assigned claims agent. Any amounts received by the assigned claims agent and reported to the department under subsections (5) and (6) of this rule will be offset against such expenditures. Subject to section (3) of this rule, costs incurred by the assigned claims agent for which reimbursement will be allowed include:

(a) All compensation paid claimant.

(b) All expenses incurred for medical services.

(c) Attorney fees paid to the claimant in addition to any compensation, and sums assessed under ORS 656.382(3) and paid by the assigned claims agent, but not fees and sums paid under ORS 656.262 (11) and 656.382(1).

(d) A reasonable amount for administrative costs at a rate proposed by the assigned claims agent and approved by the director prior to June 30 of each year. Late requests for increase on the rate of reimbursement, if approved, shall be effective on the date the request was received by the director.

(2) The department will review the request and issue the reimbursement out of the Workers' Benefit Fund.

(3) The department will conduct an annual audit of the noncomplying employer claim files processed by the assigned claims agent to validate the amount reimbursed pursuant to section (1) of this rule. Reimbursement shall not be allowed, if, upon such audit, any of the following are found to apply:

(a) Compensation has been paid as a result of untimely, inaccurate, or improper claims processing;

(b) Compensation has been paid negligently for treatment of any condition unrelated to the compensable condition;

(c) The compensability of an accepted claim is questionable and the rationale for acceptance has not been reasonably documented in accordance with generally accepted claims management procedures;

(d) The separate payments of compensation have not been documented in accordance with generally accepted accounting procedures; or

(e) The payments were made pursuant to a disposition agreement as provided by ORS 656.236 without the prior approval of the department.

(4) Under ORS 656.054 and 656.704(2), the assigned claims agent may appeal any disapproval of reimbursement made by the department under this rule as provided in OAR 436-001.

(5) When a damage action is brought against a noncomplying employer or an action is brought against a third party by an employee of a noncomplying employer or the employee's beneficiaries, or by the assigned claims agent as the paying agency for such an employee, as authorized by ORS 656.576 to 656.595, the assigned claims agent shall report the commencement and termination of such action to the department. Thereafter, at the end of each calendar year, the assigned claims agent shall report the status of all such actions that are pending.

(6) When an action against an employer, or third party is settled or if damages are recovered, the assigned claims agent shall report within (30) days to the department the amount of

the recovery retained by the assigned claims agent under ORS 656.593(1)(c).

(7) Fiscal and Business Services of the department is responsible for collecting from noncomplying employers those costs incurred by the Workers' Benefit Fund for which the assigned claims agent is entitled to reimbursement from the department under this rule. Fiscal and Business Services will inform each noncomplying employer of the liability under ORS 656.054(3) and keep the employer advised of costs incurred by the assigned claims agent.

Stat. Auth.: ORS 656.054, ORS 656.726
Stats. Implemented: ORS 656.054, 656.704, OL 2005 ch 26
Hist.: Amended 10/19/05 as WCD Admin. Order 05-066, eff. 1/2/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-080-0080 Collection of Subject Worker's Payment

(1) When the division finds the noncomplying employer has withheld monies from subject workers pursuant to ORS 656.506, it will collect such money from the noncomplying employer.

(2) Fiscal and Business Services is responsible for collecting from noncomplying employers those workers' payments not collected by the Workers' Compensation Division and referred to it by the Workers' Compensation Division.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.506
Hist.: Amended 12/3/03 as WCD Admin Order 03-065, eff. 1/1/04
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 085

PREMIUM ASSESSMENT

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436-085-0001 Authority for Rules

These rules are adopted under the director's authority contained in ORS 656.726.

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.612, 656.614, 656.726
Hist: Amended 3/23/05 as WCD Admin. Order 05-054, eff. 4/1/05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-085-0002 Purpose

The purpose of these rules is to establish guidelines to assure accurate and timely reporting and remittance of premium assessment moneys due the director.

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.612, 656.614
Hist: Amended 3/23/05 as WCD Admin. Order 05-054, eff. 4/1/05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-085-0003 Applicability of Rules

(1) These rules are effective July 1, 2011 to carry out the provisions of:

(a) ORS 656.612 – Consumer and Business Services Fund; purpose, administration, assessments, and collections.

(b) ORS 656.614 - Self-Insured Employers Adjustment Reserve; Self-Insured Employer Group Adjustment Reserve.

(2) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: 656.612, 656.614, 656.726(4)
Stats. Implemented: ORS 656.612, 656.614
Hist: Amended 5/16/11 as WCD Admin. Order 11-053, eff. 7/1/11
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-085-0005 Definitions

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

(1) "Assessable earned premium" means the amount of earned premium, minus exempted earned premium, plus large deductible premium credits or modifications that are subject to the premium assessment.

(2) "Direct earned premium" for the purposes of these rules means "assessable earned premium."

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

(4) "Earned premium" means the amount reported to the Oregon Department of Consumer and Business Services, Insurance Division in the insurer's Annual Statement, Exhibit of Premiums and Losses (Statutory Page 14), Business in the State of Oregon, Column 2 Direct Premiums Earned, Line 16 Workers' Compensation. These premiums:

(a) Exclude reinsurance accepted and are without deduction of reinsurance ceded;

(b) Are before application of any large deductible credits or modification; and

(c) Are after application of experience rating, premium discounts, retrospective rating, audit premiums, foreign terrorism premiums, domestic terrorism and catastrophic premiums, or other individual risk rating adjustments, and are exclusive of deposit premiums.

(5) "Exempted earned premium" means premium earned on insurance under jurisdiction of the federal government (e.g., U.S. Longshore and Harbor Workers' Compensation Act, Federal Employer's Liability Act, and Jones Act), and employer liability increased limits premium as reported in the insurer's Annual Statement, Exhibit of Premiums and Losses (Statutory Page 14), Business in the State of Oregon, Column 2 Direct Premiums Earned, Line 16 Workers' Compensation. All exempted earned premium must be stated on a direct basis prior to reinsurance transactions.

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

(7) "Premium Assessments" means moneys due the director under ORS 656.612 and 656.614.

(8) "Self-Insured Employer" means an employer who has been certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407.

(9) "Self-Insured Employer Group" means five or more employers certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407 and OAR 436-050-0260 through 436-050-0340.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.726
Hist: Amended 5/16/11 as WCD Admin. Order 11-053, eff. 7/1/11
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-085-0008 Administrative Review

(l) Any insurer or self-insured employer aggrieved by a proposed order or proposed assessment of civil penalty of the director issued pursuant to ORS 656.745 may request a hearing

by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

(a) The request for hearing must be sent in writing to the administrator of the Workers' Compensation Division. No hearing will be granted unless the request specifies the grounds upon which the person requesting the hearing contests the proposed order or assessment.

(b) The request for hearing must be filed with the administrator of the Workers' Compensation Division within 60 days after the mailing of the proposed order or assessment. No hearing will be granted unless the request for hearing is mailed or delivered to the administrator within 60 days after the mailing date of the proposed order or assessment.

(2) Under ORS 656.704(2), any insurer or self-insured employer that disagrees with an action or order of the director under these rules, other than as described in section (1), may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Stat. Auth.: 656.612, 656.614 & 656.726(4), 656.740
Stats. Implemented: ORS 656.704, OL 2005 ch 26, 656.735, 656.740, 656.745
Hist.: Amended 10/19/05 as WCD Admin. Order 05-067, eff. 1/2/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-085-0025 Premium Assessment; Manner and Intervals for Payments: Insurers

Insurers must report and remit premium assessment moneys to the director using a completed Form 440-910 as follows:

(1) No later than the 15th day of the second month following the last day of a calendar quarter, the insurer must report and remit premium assessment based upon the insurer's assessable earned premium for that quarter.

(2) The director may allow an insurer to report and remit premium assessments annually when the annual premium assessment is less than $1,000 for at least two consecutive years.

(3) If an eligible insurer elects not to report and pay annually, or an eligible insurer elects to revert to reporting and paying quarterly after having reported and paid annually for at least one year, it must notify the director in writing prior to the first quarter's premium assessment due date. An insurer's reporting and payment frequency remains in effect the full calendar year and cannot be changed mid-year.

(4) The director may waive an insurer's reporting liability after confirming that the insurer has no earned premium for at least four consecutive quarters. The waiver will remain in effect until premium is earned.

(5) Assessable earned premium reported by insurers will be final except for corrections made as a result of audits by the director, examinations by the Insurance Division or insurance regulator of the insurer's state of domicile, or detection by the insurer of clerical error. All such corrections will be made at the premium assessment rate in effect for the year being corrected.

(6) Each insurer, including each insurer operating within an insurer group, must submit a separate report using Form 440-910 and remittance check.

(7) The insurer must maintain sufficient documentation to support the assessable earned premium reported to the director and any adjustments or corrections. The documentation must be sufficient for the director to verify the amount reported, adjusted, or corrected.

Stat. Auth.: 656.612, 656.614, 656.726(4)
Stats. Implemented: ORS 656.612, 656.614
Hist: Amended 5/16/11 as WCD Admin. Order 11-053, eff. 7/1/11
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-085-0030 Premium Assessment; Manner and Intervals for Payments: Self-Insured Employers and Self-Insured Employer Groups

(1) As used in this rule the term "self-insured employers" includes self-insured employer groups.

(2) For premium assessment purposes the premium of all self-insured employers will be determined by using those rates filed with the Insurance Division by a single insurer effective and filed by April 1, which the director has determined will provide the lowest overall rates to all self-insured employers.

(3) Self-insured employers may elect to have their premium calculated either by using:

(a) The normal method of calculation which is manual premium modified by experience rating and premium discount; or

(b) A one-year retrospective rating plan developed and approved by the director. However, any employer becoming self-insured after July 1, may not elect a retrospective rating plan for that fiscal year.

(4) Self-insured employers are required to calculate and remit premium assessments based on the normal method of premium calculation unless the current method elected is to use the one-year retrospective rating plan.

(5) On or before May 31 of each year, the director will issue a bulletin notifying all self-insured employers of the premium rates and the retrospective rating plans developed under sections (2) and (3) of this rule.

(6) On or before July 1 of each year, every self-insured employer electing to change their current method of premium calculation must submit written notification of the election to the director. Once elected, the method may not be changed for that fiscal year and remains in effect until the self-insured employer timely elects to change the method.

(7) No later than the last calendar day of the month that follows the last day of a calendar quarter, the self-insured employer must report and remit premium assessment using Form 440-900 or Form 440-937. The premium assessment must be based upon the self-insured employer's premium for that quarter and the premium assessment rate in effect for that quarter as prescribed in OAR 440-045. For retrospective rating plans the premium assessment must be based upon 80 percent of the self-insured employer's standard premium until adjusted by retrospective rating. The director may waive the self-

insured reporting requirement after confirming that the self-insured employer has no Oregon payroll for four consecutive quarters.

(8) Notwithstanding section (7) of this rule all premium adjustments resulting from retrospective rating plans or payroll audits must be made by using the premium assessment rate or rates in effect for the period being adjusted.

(9) Retrospective rating adjustments covering periods where more than one assessment rate applied will have the adjusted premium prorated in direct proportion to the self-insured employer's standard premium for each of the periods the assessment rates differed. Total premium assessment due for the entire period will be adjusted on the same basis.

(10) The director will determine an experience rating modification for each self-insurance plan. The director will use the same method as that used by the National Council on Compensation Insurance, except that the director will use only Oregon claims and payroll exposure and will assign a policy period of July 1 through the following June 30. The self-insured employer's authorized claims processing location(s) must provide the director loss information necessary to calculate the experience rating modification. If sufficient experience is not available to promulgate an experience modification based on Oregon experience only, the director will assign the self-insured employer an experience rating modification of 1.00.

(11) When the director orders an adjustment in the experience rating modification applicable for a particular policy period, the adjustment will be applied retroactively to the beginning of the period. Any resulting increase in the assessment is payable on demand. Any resulting decrease may be applied against the next quarterly assessment payment.

(12) If payroll information submitted by the self-insured employer for use in calculating the experience rating modification is inaccurate, the director or the self-insured employer may request a revision of the experience rating modification. A payroll revision may be made only for the last three calendar years. Any experience modification using that revised payroll information will be recalculated by the director.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.612, 656.614
Hist: Amended 5/16/11 as WCD Admin. Order 11-053, eff. 7/1/11
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-085-0035 Audits

To ensure compliance with these rules, insurers, self-insured employers and self-insured employer groups will be subject to periodic audits as authorized by ORS 656.726 and 656.745.

Stat. Auth.: ORS 656.726
Stats. Implemented: 656.726, 656.745
Hist: Amended 3/23/05 as WCD Admin. Order 05-054, eff. 4/1/05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-085-0060 Assessment of Civil Penalties

(1) The director pursuant to ORS 656.745 may assess a civil penalty against an insurer, self-insured employer, or self-insured employer group.

(2) An insurer, self-insured employer or self-insured employer group in violation of OAR 436-085, 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. Each violation or each day a violation continues, will be considered a separate violation.

Stat. Auth.: 656.612, 656.614, 656.726(4)
Stats. Implemented: ORS 656.735, 656.740, 656.745
Hist: Amended 3/23/05 as WCD Admin. Order 05-054, eff. 4/1/05
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 100

WORKERS' COMPENSATION BENEFITS OFFSET

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436-100-0001 Authority for Rules

(1) These rules are promulgated under the director's authority contained in ORS 656.726 and 656.727.

Stat. Auth.: ORS 656.209, ORS 656.726 and ORS 656.727
Stats. Implemented: ORS 656.209
Hist.: WCD 2-1984 (Admin), f. & ef. 2-22-84

436-100-0002 Purpose

The purpose of these rules is to establish requirements and procedures for offsetting permanent total disability benefits against social security disability benefits.

Stat. Auth.: ORS 656.209 and ORS 656.727
Stats. Implemented: ORS 656.209
Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-100-0003 Applicability of Rules

(1) These rules are effective January 1, 2016, to carry out the provisions of ORS 656.209 and 656.727.

(2) These rules apply to:

(a) Those workers receiving awards for permanent total disability and eligible for and receiving federal social security disability benefits; and

(b) Injured workers whose period of disability under the Social Security Administration began on or after June 1, 1965.

(3) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.209 and ORS 656.727
Stats. Implemented: ORS 656.209
Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-100-0005 Definitions

(1) "Authorization" means an order issued by the Workers' Compensation Division directing the paying agent to offset the worker's permanent total disability benefits by the amount specified in the order.

(2) "Beneficiary" means an injured worker, and the spouse, child or dependent of a worker, who is entitled to receive payments under ORS 656.001 through 656.794.

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

(4) "Director" means the director of the Department of Consumer and Business Services or the director's designee.

(5) "Division" means the Workers' Compensation Division.

(6) "Federal Disability Benefit Limitation" means the amount determined under 42 USC 224(a) and Social Security Administration rules.

(7) "Offset" means a reduction of permanent total disability benefits based on the amount of federal social security disability benefits received by a worker.

(8) "Paying agency" or "paying agent" means the self-insured employer or insurer paying benefits to the worker or beneficiaries.

(9) "Performance Section" means the Performance Section of the Workers' Compensation Division.

(10) "Permanent total disability benefits" means compensation to an injured worker awarded permanent total disability compensation under ORS 656.206.

(11) "Worker" means any worker receiving permanent total disability benefits.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.209
Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-100-0006 Administration of Rules

In administration of these rules, orders of the Workers' Compensation Division are deemed orders of the director.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.209 and ORS 656.726
Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-100-0008 Administrative Review

(1) Any worker aggrieved by any offset authorization of the division may apply to the Workers' Compensation Division for a reconsideration of that authorization before requesting a hearing.

(2) Any party aggrieved may request a hearing under ORS 656.283.

Stat. Auth.: ORS 656.726 and ORS 656.727
Stats. Implemented: ORS 656.209
Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-100-0010 Criteria for Eligibility

(1) Permanent total disability benefits must be offset by the workers' social security disability benefits. However, the total combined benefit, permanent total disability benefits plus social security disability benefits, must not be offset to an amount less than the greater of:

(a) The amount the worker would have received under ORS chapter 656; or

(b) The Federal Disability Benefit Limitation.

(2) Permanent total disability benefits must not be paid by the paying agent in an amount greater than authorized by ORS Chapter 656.

(3) Offset of permanent total disability benefits must be made by a paying agent only in an amount and as authorized by the director.

(4) Offset of permanent total disability benefits will be authorized by the director only upon actual receipt of federal social security disability benefits by the injured worker.

Stat. Auth.: ORS 656.209 and ORS 656.727
Stats. Implemented: ORS 656.209
Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-100-0020 Requirements of Workers

(1) Workers entitled to receive permanent total disability benefits must make application for federal social security disability benefits.

(2) Workers and eligible beneficiaries must, upon department request, execute a release form authorizing the Social Security Administration to make disclosure to the department of such information regarding the injured workers as will enable the department to carry out the provisions of ORS 656.209 and these rules.

(3) Whenever there is a change in the federal social security beneficiary eligibility, the worker must notify the Performance Section.

(4) Upon request of the department, the worker may be required at any time to furnish additional information regarding social security disability benefits.

Stat. Auth.: ORS 656.209 and ORS 656.727
Stats. Implemented: ORS 656.209 and ORS 656.727
Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-100-0030 Authorization of Offset; Effective Date

(1) Authorization issued by the department will be directed to the paying agent with a copy to the injured worker.

(2) A paying agent making payment of permanent total disability benefits will be entitled to social security disability offset only as authorized by the department.

(3) The department will review the social security offset calculation when notified of a change in the status of a worker subject to social security offset. An amended authorization will be issued, if necessary.

(4) Whenever there is a change in eligibility status of the worker or any one of the worker's beneficiaries receiving benefits for permanent total disability subject to offset, the paying agent must notify the Performance Section.

(5) The paying agent must, immediately upon the death of a worker, terminate payment of previously authorized permanent total disability benefits offset and begin payment of other compensation due under ORS chapter 656, if any.

(6) The effective date of offset must be the effective date established in the authorization.

Stat. Auth.: ORS 656.209 and ORS 656.727
Stats. Implemented: ORS 656.209 and ORS 656.727
Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-100-0040 Sanctions Against Worker for Failure to Cooperate With the Department

(1) Any worker entitled to receive permanent total disability benefits who fails to comply with these rules will be subject to suspension of benefits until the worker has complied.

(2) If a worker fails to comply with these rules, the director will make a written demand upon the worker by personal service or registered mail. If the worker fails to comply within 20 days of receipt of the demand, the director may authorize suspension of benefits until the worker complies.

(3) An order of suspension of benefits will continue in force from the date issued until the date the worker actually complies with these rules.

(4) No compensation will become due or be payable during a period of suspension of benefits.

Stat. Auth.: ORS 656.209 and ORS 656.727
Stats. Implemented: ORS 656.209 and ORS 656.727
Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 105

EMPLOYER-AT-INJURY PROGRAM

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436-105-0001 Authority for Rules

The director has adopted OAR Chapter 436, Division 105 under the authority of ORS 656.622 and 656.726.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Adopted 8/14/01 as WCD Admin. Order 01-057, eff. 10/1/01

436-105-0002 Purpose of Rules

(1) The Employer-at-Injury Program encourages the early return to work of injured workers by providing incentives to employers.

(2) The Employer-at-Injury Program is activated by the employer and administered by the insurer.

(3) The program consists of Wage Subsidy, Worksite Modification, and Employer-at-Injury Program Purchases.

(4) These rules explain:

(a) The assistance and reimbursements available from the Employer-at-Injury Program;

(b) Who is qualified for the assistance and reimbursement; and

(c) How to receive assistance and reimbursements.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 11/1/07 as WCD Admin. Order 07-065, eff. 12/1/07
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-105-0003 Applicability of Rules

(1) These rules apply to:

(a) All individual Employer-at-Injury programs started on or after the effective date of these rules, unless otherwise provided in subsections (b) or (c);

(b) All wage subsidy reimbursement requests when the wage subsidy period began on or after the effective date of these rules; and

(c) All reimbursement requests received by the division on or after the effective date of these rules for worksite modification or program purchases, regardless of when the purchase was made.

(2) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 4/12/13 as Admin. Order 13-054, eff. 7/1/13
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-105-0005 Definitions

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

(1) "Administrator" means the Administrator of the Workers' Compensation Division, or the administrator's delegate for the matter.

(2) "Client" means a person to whom workers are provided under contract and for a fee on a temporary or leased basis.

(3) "Consumables" means purchases required to support the functioning of tools or equipment utilized during transitional work.

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

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

(6) "Employer-at-Injury" means the organization that employed the worker when the worker:

(a) Sustained the injury or occupational disease;

(b) Made the claim for aggravation; or

(c) Requested an Own Motion opening under ORS 656.278.

(7) "Fund" means the Workers' Benefit Fund.

(8) "Insurer" means the insurance company or self-insured employer responsible for the workers' compensation claim.

(9) "Premium" means the monies paid to an insurer for the purpose of purchasing workers' compensation insurance.

(10) "Regular employment" means the employment the worker held at the time of:

(a) Injury;

(b) The claim for aggravation; or

(c) Own Motion opening under ORS 656.278.

(11) "Reimbursable wages" means the worker's gross wages for the Wage Subsidy period.

(12) "Skills building" means a class or course of instruction taken by the worker for the purpose of enhancing an existing skill or developing a new skill. When skills building is the transitional work, the worker must agree in writing to take the class or course of instruction.

(13) "Transitional Work" means temporary work with the employer-at-injury which is not the worker's full duty regular work and is assigned because the worker cannot perform full duty regular work. Transitional work must be within the worker's injury-caused limitations and may be created through modification of the worker's regular work, job restructuring, assistive devices, worksite modification(s), reduced hours, or reassignment to another job. Transitional work must be within the employer's course and scope of trade or profession, unless the work is "skills building."

(14) "Worker Leasing Company" means the person which provides workers, by contract and for a fee, as prescribed in ORS 656.850.

(15) "Work site" means a primary work area available for a worker to use to perform the required job duties. The work site may be the employer's, client's, or worker's premises, property, and equipment used to conduct business under the employer's or client's direction and control. A work site may include a worker's personal property or vehicle if required to perform the job.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-059, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-105-0006 Administration of Rules

(1) Orders issued by the division to enforce ORS 656.622 or these rules are orders of the director.

(2) The department maintains the financial integrity of the fund and all reimbursement is subject to the availability of funds. If the funds are too low for all reimbursements, the director has the final authority to determine how the funds will be disbursed.

(3) The director may use monies from the fund for activities to provide information about and encourage the reemployment of injured workers. A maximum of $250,000 may be used in a fiscal year, July 1 to June 30. The director must approve all expenditures. Activities include, but are not limited to:

(a) Advertisements and promotion of reemployment assistance programs and associated production costs; and

(b) Public reemployment assistance program conferences and workshops.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Adopted 8/14/01 as WCD Admin. Order 01-057, eff. 10/1/01

436-105-0008 Reconsideration/Appeal to the Director

(1) The division will deny any reimbursement for Employer-at-Injury Program assistance it finds in violation of these rules. The division has the discretion to deny any reimbursement of Employer-at-Injury Program assistance it determines is not reasonable, practical, or feasible, or considers an abuse of the program.

(2) Parties directly affected by a division Employer-at-Injury Program decision may request a reconsideration by sending a written request for reconsideration to the administrator no later than 60 days after the date the decision is issued. Facsimiles that are legible and complete are acceptable and will be processed the same as originals. Reconsideration must precede a director's review.

(3) The request for reconsideration must specify the reasons why the decision is appealed and may include additional documentation. No reconsideration will be granted unless the request meets the requirements of this rule.

(4) The division will reconsider the decision and notify all directly affected parties of its decision in writing. The affected parties may request a director's review by sending a written request no later than 60 days after the date the reconsideration was issued. The request must specify the reasons why the decision is appealed and may include additional documentation.

(5) The director may require any affected party to provide information or to participate in the director's review. If the party requesting the director's review fails to participate without reasonable cause as determined by the director, the director may dismiss the review.

(6) The director's review decision will be issued in writing and all directly affected parties will be notified. The director's review decision is final and not subject to further review by any court or other administrative body.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 11/1/07 as WCD Admin. Order 07-065, eff. 12/1/07
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-105-0500 Insurer Participation in the Employer-At-Injury Program

(1) An insurer must be an active participant in providing reemployment assistance with the employer's consent. Participation includes issuing notices of the available assistance and administering the Employer-at-Injury Program as specified in these rules.

(2) The insurer will notify the worker and employer-at-injury in writing of the assistance available from the Employer-at-Injury Program. A notice must be issued:

(a) Upon acceptance or reopening of a claim; and

(b) Within five days of a worker's first release for work after claim opening unless the release is for regular work.

(3) The notices of Employer-at-Injury Program assistance must contain the following language:

(a) The notice to the worker must appear in bold type as follows:

The Reemployment Assistance Program provides Oregon's qualified injured workers help with staying on the job or getting back to work. Because of your injury, your employer may be eligible for assistance to return you to transitional work through the Employer-at-Injury

Program while your claim is open. Your employer may contact [insurer name and phone number].

(b) The notice to the employer-at-injury must appear in bold type as follows:

Because of your worker's injury, you may be eligible for assistance through the Employer-at-Injury Program to return the worker to transitional work while the worker's claim is open. To learn more about the assistance available from the program, please call [insurer name and phone number].

(4) The insurer will administer the Employer-at-Injury Program according to these rules. The insurer must assist an employer to:

(a) Obtain a qualifying medical release, pursuant to section (5) of this rule, from the medical service provider;

(b) Identify a transitional work position;

(c) Process employer wage subsidy requests as specified in OAR 436-105-0520(1);

(d) Make worksite modification purchases as specified in OAR 436-105-0520(2);

(e) Make Employer-at-Injury Program purchases as specified in OAR 436-105-0520(3); and

(f) Request Employer-at-Injury Program reimbursement from the division as specified in OAR 436-105-0540.

(5) For purposes of the Employer-at-Injury Program, medical releases must meet the following criteria:

(a) All medical releases must be dated and related to the compensable injury or occupational disease or, if the claim has not been accepted or denied, the claimed workers' compensation injury or occupational disease. The date the medical release is issued by the worker's medical service provider is considered the effective date if an effective date is not otherwise specified.

(b) Two types of medical release qualify under these rules:

(A) A medical release that states the worker's specific current or projected restrictions; or

(B) A statement by the medical service provider that indicates the worker is not released to regular employment accompanied by an approval of a job description which includes the job duties and physical demands required for the transitional work.

(c) A medical release must cover any period of time for which benefits are requested.

(6) For the purposes of the Employer-at-Injury Program, a medical release, and any restrictions it contains, remains in effect until another medical release is issued by the worker's medical service provider. An employer or insurer may get clarification about a medical release from the medical service provider who issued the release any time prior to submitting the reimbursement request.

(7) The insurer must maintain all records of the Employer-at-Injury Program for a period of three years from the date of the last Employer-at-Injury Program reimbursement request. The insurer will maintain the following information at the authorized claim processing location(s):

(a) The worker's claim file;

(b) Documentation from the worker's medical service provider that the worker is unable to perform regular employment due to the injury and dated copies of all work releases from the worker's medical service provider;

(c) A legible copy of the worker's payroll records for the wage subsidy period as follows:

(A) Payroll records must state the payroll period, wage rate(s), and the worker's gross wages for the wage subsidy period. The payroll record must also include the dates and hours worked each day if the worker has hourly restrictions;

(B) Insurers and employers may supplement payroll records with documentation of how the worker's earnings were calculated for the wage subsidy. Supplemental documentation may be used to determine a worker's work schedule, wages earned on a particular day, dates of paid leave, or to clarify any other necessary information not fully explained by the payroll record;

(C) If neither the payroll record(s) nor supplemental documentation show the amount of wages earned by the worker for reimbursable partial payroll periods, the allowable reimbursement amount may be calculated as follows:

(i) Divide the gross wages by the number of days in the payroll period for the daily rate; and

(ii) Multiply the daily rate by the number of eligible days; and

(D) If a partial day's reimbursement is requested after a worker is released for transitional work, or prior to returning from a medical appointment with a regular work release, documentation of the time of the medical appointment and hours and wages of transitional work must be provided for those days.

(d) A legible copy of proof of purchase, providing proof the item was ordered during the Employer-at-Injury Program period and proof of payment of the item(s) for worksite modification purchases and Employer-at-Injury Program purchases;

(e) Written documentation of the insurer's decision to approve worksite modifications;

(f) Documentation of the transitional work, which must include the start date, wage and hours, and a description of the job duties;

(g) Documentation that payments for a home care worker were made to the Oregon Department of Human Services/Oregon Health Authority, if applicable;

(h) The written acceptance by the worker when skills building is the transitional work; and

(i) Documentation, including course title and curriculum for a class or course of instruction when Employer-at Injury Program purchases are requested.

Stat. Auth.: ORS 656.340, 656.622, 656.726(4)
Stats. Implemented: ORS 656.340, 656.622
Hist.: Amended 1/29/15 as WCD Admin. Order 15-054, eff. 3/1/15

See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-105-0510 Eligibility and End of Eligibility for the Employer-at-Injury Program

(1) The employer must maintain Oregon workers' compensation insurance coverage.

(2) The employer must be the employer at injury as defined in OAR 436-105-0005.

(3) The employer must be employing an eligible worker.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 10-3-2012 as Admin. Order 12-057, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-105-0511 Worker Eligibility

(1) The worker must have an Oregon workers' compensation injury or occupational disease claim at the time of the Employer-at-Injury Program.

(2) The worker must not be covered by the Injured Inmate Law.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist: Amended 10-3-2012 as Admin. Order 12-057, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-105-0512 End of Eligibility

The Employer-at-Injury Program will end:

(1) When the worker or employer no longer meets the eligibility provisions stated in OAR 436-105-0510 and OAR 436-105-0511;

(2) When the worker's claim is closed or denied;

(3) When sanctions under OAR 436-105-0560 preclude eligibility;

(4) When the insurer ends the Employer-at-Injury Program at any time while the worker's claim is open; or

(5) Two years after the original date of acceptance of a non-disabling claim.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist: Amended 10-3-2012 as Admin. Order 12-057, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-105-0520 Assistance Available from the Employer-at-Injury Program

The Employer-at-Injury Program may be used only once per worker per claim opening for a nondisabling claim or a disabling claim. If a nondisabling claim becomes a disabling claim after one year from the date of acceptance, the disabling claim is considered a new opening and the Employer-at-Injury Program may be used again. Assistance available includes:

(1) Wage subsidy, which provides 45 percent reimbursement of the worker's gross wages for the wage subsidy period. Wage subsidy benefits are subject to the following conditions:

(a) A wage subsidy may not exceed 66 workdays and must be completed within a 24 consecutive month period;

(b) A wage subsidy may not start or end with paid leave;

(c) If the worker has hourly restrictions, reimbursable paid leave must be limited up to the maximum number of hours of the worker's hourly restrictions. Paid leave exceeding the worker's hourly restrictions is not subject to reimbursement;

(d) Any day during which the worker exceeds his or her injury-caused limitations will not be reimbursed. If, however, an employer uses a time clock, a reasonable time not to exceed 30 minutes per day will be allowed for the worker to get to and from the time clock and the worksite without exceeding the worker's hourly restrictions.

(2) Worksite modification.

(a) Worksite modification means altering a worksite by renting, purchasing, modifying, or supplementing equipment to:

(A) Enable a worker to perform the transitional work within the worker's limitations that resulted in the worker's EAIP eligibility;

(B) Prevent a worsening of the worker's compensable injury or occupational disease; or

(C) If the claim has not been accepted or denied, to prevent a worsening of the claimed workers' compensation injury or occupational disease.

(b) Worksite modification assistance is subject to the following conditions:

(A) The insurer determines the appropriate worksite modifications for the worker;

(B) The insurer documents its reasons for approving the modifications;

(C) The worksite modifications must be ordered during the Employer-at-Injury Program; and

(D) Worksite modification items become the employer's property upon the end of the Employer-at-Injury Program.

(3) Employer-at-Injury Program purchases, which are limited to:

(a) Tuition, books, fees, and materials required for a class or course of instruction to enhance an existing skill or develop a new skill when skills building is used as transitional work or when required to meet the requirements of the transitional work position. Maximum expenditure is $1,000. Tuition, books, fees, and required materials will be provided under the following conditions:

(A) The insurer determines the instruction will help the worker enhance an existing skill or develop a new skill, and documents its decision; and

(B) The worker begins participation in the class or course while eligible for the Employer-at-Injury Program;

(b) Clothing required for the job, except clothing the employer normally provides. Clothing becomes the worker's property. Maximum expenditure is $400.

(4) Employer-at-Injury Program purchases of tools and equipment, including consumables, must be required for the worker to perform transitional work. These purchases will be the employer's property.

(5) Worksite modification and purchases of tools and equipment are limited to a combined maximum reimbursement of $5,000.

(6) All modifications and purchases made by the employer in good faith are reimbursable, even if the worker refuses to return to work, or if the worker agreed to take part in training and then later refused to attend training.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 1/29/15 as Admin. Order 15-054, eff. 3/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-105-0530 Employer-at-Injury Program Procedures for Concurrent Injuries

(1) A worker is eligible for only one Employer-At-Injury Program at a time.

(2) When a worker in an Employer-at-Injury Program incurs a new compensable injury, transitional work for the first Employer-At-Injury is considered regular work for the second Employer-at-Injury Program.

(3) If the new injury makes the first Employer-at-Injury Program unsuitable, the worker may be eligible for a second Employer-at-Injury Program under the new injury.

(4) When the worker is no longer eligible for the second Employer-At-Injury Program, the first Employer-At-Injury Program may be resumed if the employer and worker still meet eligibility criteria under that claim.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 5/16/03 as WCD Admin. Order 03-057 eff. 6/8/03
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-105-0540 Employer-at-Injury Program Reimbursement Procedures

(1) Reimbursements may include wage subsidy, Employer-at-Injury Program purchases, and worksite modification.

(2) The insurer is entitled to a program administrative cost of $120.00 for the first reimbursement request of an Employer-at-Injury Program. A subsequent request for reimbursement for the same Employer-at-Injury Program is not entitled to an additional program administrative cost.

(3) The insurer must receive all required documentation for reimbursement within one year from the end of the Employer-at-Injury Program in order to qualify for reimbursement. The insurer must date stamp each reimbursement request document with the receipt date.

(4) The insurer must submit the request for reimbursement (Form 2360) to the division within one year and 30 days from the end of the Employer-at-Injury Program.

(5) The employer-at-injury reimbursement request must be a minimum of $100. The associated administrative costs will also be eligible for reimbursement.

(6) Subsequent requests less than $100 will be eligible for reimbursement. However, the requests will not be eligible for reimbursement of a subsequent administrative cost.

(7) If the original request was less than $100, but the amended request is at least $100, the request and the associated administrative costs will be eligible for reimbursement.

(8) When the division finds the insurer has submitted an Employer-at-Injury Program reimbursement request that is incomplete or contains an error, the division may return the form to the insurer for correction. The insurer has 60 days from the date the insurer receives the reimbursement request, or one year and 30 days from the end of Employer-at-Injury Program eligibility, whichever is greater, to make the corrections and return the corrected form to the division.

(9) The insurer may send an Employer-at-Injury Program reimbursement request to the division when a claim was initially denied and was subsequently accepted after the Employer-at-Injury Program eligibility ended and more than one year and 30 days have passed. In that case, the insurer must send a completed Employer-at-Injury Program reimbursement request to the division within 60 days of the first order or stipulation and order accepting the claim. A copy of the order accepting the claim, or stipulation and order accepting the claim must be attached.

(10) The insurer may request reimbursement for a qualifying Employer-at-Injury Program that took place prior to claim denial even if the claim is denied at the time the reimbursement request is sent to the division.

(11) Amended reimbursement requests must be sent to the division within one year and 30 days from the end of the Employer-at-Injury Program eligibility except as provided in section (6) of this rule. The insurer may not request additional administrative cost reimbursement for filing an amended reimbursement request.

(12) An amended reimbursement request must clearly state that it is an amendment and cite the corrected information.

(13) The insurer will not use Employer-at-Injury Program costs subject to reimbursement for rate making, individual employer rating, dividend calculations, or in any manner that would affect the employer's insurance premiums or premium assessments with the present or a future insurer. The insurer must be able to document that Employer-at-Injury Program costs do not affect the employer's rates or dividend.

(14) If a preferred worker employed by an eligible employer with active premium exemption incurs a new injury, the claim is subject to claim cost reimbursement under OAR 436-110. If the worker subsequently enters an Employer-at-Injury Program, program costs are to be separated from claim costs and will not be reimbursed as claim costs.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 10-3-2012 as Admin. Order 12-057, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-105-0550 Audits

(1) Insurers and employers are subject to periodic program and fiscal audits by the division. All reimbursements are subject to subsequent audits, and may be disallowed on any of

the grounds set forth in these rules. Disallowed reimbursements must be repaid to the department.

(2) The audit may include but not be limited to a review of the records required in OAR 436-105-0500(7).

(3) When conflicting documentation exists, the division will utilize a preponderance of evidence standard to decide eligibility for reimbursement and if there is no clear preponderance, reimbursement will be allowed.

(4) The division reserves the right to visit the work site to determine compliance with these rules.

Stat. Auth.: ORS 656.455, 656.622, 656.726(4), 731.475
Stats. Implemented: ORS 656.455, 656.622, 731.475
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-059, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-105-0560 Sanctions

(1) Any person who knowingly makes a false statement or misrepresentation to the director or an employee of the director for the purpose of obtaining any benefits or reimbursement from the Employer-at-Injury Program or who knowingly misrepresents the amount of a payroll, or knowingly submits a false payroll report, is subject to penalties under ORS 656.990.

(2) Reasons for the director to sanction an insurer, self-insured employer, employer or their representative include, but are not limited to:

(a) Misrepresenting information in order to receive Employer-at-Injury Program assistance;

(b) Making a serious error or omission which resulted in the division approving reimbursement in error;

(c) Failing to respond to employer requests for assistance or failing to administer Employer-at-Injury Program assistance; or

(d) Failure to comply with any condition of these rules.

(3) Sanctions by the director may include one or more of the following:

(a) Ordering the person to take corrective action within a specific period of time;

(b) Ordering the person being sanctioned to repay the department all, or part, of the monies reimbursed, with or without interest at a rate set by the department. The order may include the department's legal costs;

(c) Ending the employer's eligibility to use the Employer-at-Injury Program for a specific period of time; and

(d) Pursuing civil penalties under ORS 656.745 or criminal action against the party.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622, 656.745, 656.990
Hist.: Adopted 8/14/01 as WCD Admin. Order 01-057, eff. 10/1/01

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 110

PREFERRED WORKER PROGRAM

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436-110-0001 Authority for Rules

The director has adopted OAR Chapter 436, Division 110 under authority of ORS 656.622 and 656.726.

Stat. Auth.: ORS 656.622, 656.726(4); Stats. Implemented: ORS 656.622
Hist.: Amended 8/14/01 as WCD Admin. Order 01-056, eff. 10/1/01
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0002 Purpose of Rules

(1) These rules explain what assistance and reimbursements are available from the Preferred Worker Program, who is qualified, and how to receive assistance and reimbursements.

(2) The Preferred Worker Program encourages the reemployment of workers whose on-the-job injuries result in disability which may be a substantial obstacle to employment by providing assistance from the Workers' Benefit Fund to eligible injured workers and to the employers who employ them.

(3) The Preferred Worker Program is a worker and employer-at-injury -activated program.

Stat. Auth.: ORS 656.622, 656.726(4); Stats. Implemented: ORS 656.622
Hist.: Amended 12/5/05 as WCD Admin. Order 05-079, eff. 1/1/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0003 Applicability of Rules

(1) These rules apply to all requests for Preferred Worker Program reemployment assistance received by the division on or after the effective date of these rules.

(2) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.622, 656.726(4); Stats. Implemented: ORS 656.622
Hist.: Amended 10-3-2012 as Admin. Order 12-058, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0005 Definitions

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

(1) "Administrator" means the Administrator of the Workers' Compensation Division, or the administrator's delegate for the matter.

(2) "Client" means a person to whom workers are provided under contract and for a fee on a temporary or leased basis.

(3) "Date of eligibility" means the date the division determines a worker is a preferred worker.

(4) "Date of hire" means the date the worker starts work as a preferred worker.

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

(6) "Disability" means permanent physical or mental restriction(s) or limitation(s) caused by an accepted disabling Oregon workers' compensation claim that limits the worker from performing one or more of the worker's regular job duties.

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

(8) "Division approval" means a preferred worker agreement signed by an authorized division representative.

(9) "Employer at injury" means the organization in whose employ the worker sustained the injury or occupational disease.

(10) "Exceptional disability" means a disability equal to or greater than the complete loss, or loss of use, of both legs. Exceptional disability also includes brain injury that results in impairment equal to or greater than a Class III as defined in OAR 436-035. The division will determine whether a worker has an exceptional disability based upon the combined effects of all of the worker's Oregon compensable injuries resulting in permanent disability.

(11) "Fund" means the Workers' Benefit Fund.

(12) "Insurer" means the insurance company or self-insured employer responsible for the workers' compensation claim.

(13) "Premium" means the monies paid to an insurer for the purpose of purchasing workers' compensation insurance.

(14) "Regular employment" means the job the worker held at the time of the injury, claim for aggravation, or own motion opening.

(15) "Reimbursable wages" means the worker's gross wages for the wage subsidy period.

(16) "Worksite" means a primary work area that is in Oregon, already constructed and available for a worker to use to perform the required job duties. The worksite may be the employer's, worker's, or worker leasing company's client's premises, property, and equipment used to conduct business under the employer's or client's direction and control. A worksite may include a worker's personal property or vehicle if required to perform the job. If the "worksite" is mobile, it must be available in Oregon for inspection and modification.

Stat. Auth.: ORS 656.622, 656.726(4); Stats. Implemented: ORS 656.622
Hist.: Amended 10-3-2012 as Admin. Order 12-058, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0006 Administration of Rules

(1) Orders issued by the division to enforce ORS 656.622 or these rules are orders of the director.

(2) The department maintains the financial integrity of the fund and all reimbursement is subject to the availability of funds. If the funds are too low for all reimbursements, the director has final authority to determine how the funds will be disbursed.

(3) The director may use moneys from the fund for activities to provide information about and encourage reemployment of injured workers. A maximum of $250,000 may be used in a fiscal year, July 1 to June 30. The director must approve all expenditures. Activities include, but are not limited to:

(a) Advertisements and promotion of reemployment assistance programs and associated production costs; and

(b) Public reemployment assistance program conferences and workshops.

Stat. Auth.: ORS 656.622, 656.726(4); Stats. Implemented: ORS 656.622
Hist.: Amended 8/14/01 as WCD Admin. Order 01-056, eff. 10/1/01
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0007 Reconsideration/Appeal to the Director

(1) The division will deny any request for Preferred Worker Program assistance it finds is in violation of these rules. The division has the discretion to deny a request it determines is not reasonable, practical, or feasible, or considers an abuse of the program.

(2) Parties directly affected by a division reemployment assistance decision may request a reconsideration by sending a written request for reconsideration to the administrator no later than 60 days after the date the decision is issued. Facsimiles that are legible and complete are acceptable and will be processed the same as originals. Reconsideration must precede a director's review.

(3) The request for reconsideration must specify the reasons why the decision is appealed. No reconsideration will be granted unless the request meets the requirements of this subsection.

(4) The division will reconsider the decision prior to a director's review and will notify all affected parties of its decision upon reconsideration.

(5) If, upon reconsideration, the division upholds the original decision, the director's review will begin.

(6) The director may require any affected party to provide information or to participate in the director's review. If the party requesting the director's review fails to participate without reasonable cause as determined by the director, the director may dismiss the review.

(7) The director's review decision will be issued in writing. The director's review decision is final and not subject to further review by any court or other administrative body.

Stat. Auth.: ORS 656.622, 656.726(4); Stats. Implemented: ORS 656.622
Hist.: Amended 11/1/07 as WCD Admin. Order 07-066, eff. 12/1/07
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0150 Pilot Projects

(1) The director may develop one or more pilot projects to test alternatives to the current system of reemploying preferred workers.

(2) Notwithstanding any other provision of these rules, the director and others participating in pilot projects are bound by the terms of the pilot project.

Stat. Auth.: ORS 656.622, 656.726(4); Stats. Implemented: ORS 656.622
Hist.: Adopted 6/5/13 as WCD Admin. Order 13-055, eff. 6/7/13

436-110-0240 Insurer Participation in the Preferred Worker Program

(1) The insurer of the employer at injury must be an active participant in providing reemployment assistance. Participation includes issuing notices of the assistance available from the preferred worker program.

(2) The insurer must notify the worker and employer at injury in writing of the reemployment assistance available from the fund. A notice must be issued:

(a) Within 5 days of a worker's release for work after the worker has been declared medically stationary by the attending physician;

(b) Upon determination of eligibility or ineligibility of the worker for vocational assistance under OAR 436-120; and

(c) Upon approval of a claim disposition agreement.

(3) Pursuant to section (2) of this rule, the notice to the worker must appear in bold type and contain the following language:

The preferred worker program helps Oregon's injured workers get back to work. To find out whether you qualify, contact the preferred worker program at one of the telephone numbers, fax numbers, mailing addresses, or e-mail address listed below.

For the Salem office call: 503-947-7588, 1-800-445-3948, or FAX 503-947-7581.

For the Medford office call: 541-776-6032, 1-800-696-7161, or FAX 541-776-6022.

Or write the preferred worker program at: 350 Winter St NE, P.O. Box 14480, Salem, Oregon 97309-0405. Or write to the preferred worker program at: pwp.oregon@state.or.us

(4) Under section (2) of this rule, the notice to the employer must appear in bold type and contain the following language:

As the employer of an injured worker, you may be eligible for valuable preferred worker program incentives if the worker cannot return to regular work and has permanent limitations caused by the injury.

If the worker's preferred worker program eligibility has not been determined, you may contact the Workers' Compensation Division for an eligibility review.

To be eligible for exemption from paying workers' compensation premiums for this worker for three years, you must:

• Bring back your preferred worker to a new or modified job; and

• Notify us within 90 days of the date the worker is determined eligible or within 90 days of the date you bring the worker back to work, whichever is later.

To request all other preferred worker program benefits, you must contact the Workers' Compensation Division within 180 days of the worker's claim closure date.

To find out more about the preferred worker program, contact the program at one of the telephone numbers, fax numbers, or addresses listed below.

For the Salem office call: 503-947-7588, 1-800-445-3948, or FAX 503-947-7581.

For the Medford office call: 541-776-6032, 1-800-696-7161, or FAX 541-776-6022.

Or write the preferred worker program at: 350 Winter St NE, P.O. Box 14480, Salem, Oregon 97309-0405. Or write to the preferred worker program at: pwp.oregon@state.or.us

(5) The insurer must provide the division with preferred worker information in the form and format the director prescribes in OAR 436-030, upon the following:

(a) Claim closure according to ORS 656.268;

(b) Within 30 calendar days from the insurer's receipt of the earliest opinion and order of an administrative law judge, order on reconsideration, order on review by the board, decision of the Court of Appeals, or stipulation that grants initial permanent disability after the latest opening of the worker's claim; and

(c) Approval of a claim disposition agreement according to ORS 656.236 and documented medical evidence indicates permanent disability exists as a result of the injury or disease, and the worker is unable to return to regular employment.

Stat. Auth.: ORS 656.340, 656.622, 656.726(4)
Stats. Implemented: ORS 656.340(1), (2), (3); 656.622; 656.726(4)
Hist.: Amended 10-3-2012 as Admin. Order 12-058, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0290 Employer at Injury Use of the Preferred Worker Program

The conditions for the employer at injury to activate the preferred worker program include:

(1) To be eligible for premium exemption the employer at injury must:

(a) Bring back its preferred worker to a new or modified job;

(b) Contact the Workers' Compensation Division for a preferred worker eligibility review if the worker's eligibility has not been determined; and

(c) Notify its insurer within 90 days from the date of eligibility or the date of hire, whichever is later.

(2) For all other preferred worker program benefits the employer at injury must request preferred worker program assistance from the division within 180 days of the worker's claim closure date, with the following exception: When worksite modification are provided, and the modifications are completed and verified by the division more than 150 days after the worker's claim closure date, the employer at injury will have 30 calendar days from the verification date to request other assistance.

(3) In calculating the 180 day period under this rule, the claim closure date will not be included, and if the 180th day falls on a Saturday, Sunday, or legal holiday, the next business day will be considered the end of the 180 day period.

(4) The worker must agree to accept the new or modified regular job in writing. The job offer must include:

(a) The start date. If the job starts after the modifications are in place, so note;

(b) Wage and hours;

(c) Job site location; and

(d) Description of job duties.

(5) If the employer at injury uses worksite modification assistance and the employer or worker later requests additional modifications for the same job, the employer's worksite modification benefit will be exhausted before using the worker's worksite modification benefits.

(6) All other provisions under OAR 436-110 apply unless otherwise indicated.

Stat. Auth.: ORS 656.726(4), 656.622; Stats. Implemented: ORS 656.622
Hist.: Amended 9-15-10 as WCD Admin. Order 10-055, eff. 10-12-10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0310 Eligibility and End of Eligibility for the Preferred Worker Program

(1) The eligibility requirements for an employer, except as provided in OAR 436-110-0345(1) for Employment Purchases, are:

(a) The employer has and maintains Oregon workers' compensation insurance coverage;

(b) The employer complies with the Oregon Workers' Compensation Law;

(c) The employer must offer or provide employment to an eligible Preferred Worker who is a subject Oregon worker according to ORS 656.027;

(d) If the employer is a worker leasing company, it must be licensed with the division; and

(e) The employer is not currently ineligible for Preferred Worker benefits under OAR 436-110-0900.

(2) The eligibility requirements for a worker are:

(a) The worker has an accepted disabling Oregon compensable injury or occupational disease. Injuries covered by the Injured Inmate Law do not qualify;

(b) Medical evidence indicates that, because of injury-caused limitations, the worker will not be able to return to regular employment as defined in OAR 436-110-0005 under the most recent disabling claim or claim opening. If the worker is not eligible under the most recent disabling claim or claim opening, eligibility may be based on the most recent disabling claim closure where injury-caused permanent restrictions prevented the worker from return to regular employment;

(c) Medical documentation indicates permanent disability exists as a result of the injury or disease, whether or not an order has been issued awarding permanent disability; and

(d) The worker is authorized to work in the United States.

(3) A worker may not use Preferred Worker benefits for self-employment unless the injury that gave rise to the worker's eligibility for the Preferred Worker Program occurred in the course and scope of self-employment. In that case, the worker may use the benefits to return to the same self-employment or for employment other than self-employment.

(4) Reasons for ending Preferred Worker Program eligibility include, but are not limited to, the following:

(a) Misrepresentation or omission of information by a worker or employer to obtain assistance;

(b) Failure of a worker or employer to provide requested information or cooperate;

(c) Falsification or alteration of a Preferred Worker card or a Preferred Worker Program Agreement;

(d) Conviction of fraud in obtaining workers' compensation benefits;

(e) The worker no longer meets the eligibility requirements under section (2) of this rule;

(f) The worker or employer is sanctioned from receiving reemployment assistance in accordance with OAR 436-110-0900;

(g) The employer does not maintain Oregon workers' compensation insurance coverage, except as provided in OAR 436-110-0345(1) for Employment Purchases;

(5) The division retains the right to reinstate Preferred Worker Program eligibility if eligibility was ended prematurely or in error, or the employer has reinstated or obtained workers' compensation insurance coverage.

(6) A worker found ineligible because he/she was not authorized to work in the United States may request a redetermination of eligibility after providing the division with documentation that he/she is authorized to work in the United States.

Stat. Auth.: ORS 656.622, 656.726(4); Stats. Implemented: ORS 656.622
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-060, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0320 Preferred Worker Cards

(1) The division issues a Preferred Worker Identification card to eligible workers. The card identifies the worker as being eligible to offer an employer Preferred Worker Program assistance. If a Preferred Worker loses the card, the division will issue a replacement card.

(2) The division issues this card as follows:

(a) Automatically at the time of claim closure based upon insurer submission of Preferred Worker information as specified in OAR 436-110-0240(5);

(b) When the worker or their representative request a card, and the worker is eligible; or

(c) Any other time the division finds a worker eligible.

(3) The division may inactivate a Preferred Worker card if:

(a) The Preferred Worker card was issued in error; or

(b) Any reason for ending Preferred Worker Program eligibility as specified in OAR 436-110-0310(4) applies.

Stat. Auth.: ORS 656.622, 656.726(4); Stats. Implemented: ORS 656.622
Hist.: Amended 6/12/08 as WCD Admin. Order 08-058, eff. 7/1/08
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0325 Premium Exemption General Provisions

(1) The purpose of premium exemption is to provide an incentive to employers to hire preferred workers.

(2) Premium exemption releases an employer from paying workers' compensation insurance premiums and premium assessments on a preferred worker for three years from the date premium exemption started. While using premium exemption, the employer does not report, and the insurer cannot use, the preferred worker's payroll for the calculation of insurance premiums or premium assessments. However, the employer must report and pay workers' compensation employer assessments and withhold employee contributions as required by OAR 436-070. The employer must start paying insurance premiums and premium assessments when premium exemption ends.

(3) Premium exemption cannot be used for regular employment unless the job is modified to accommodate the worker's injury-caused limitations.

(4) To qualify for premium exemption the employer at injury or aggravation must bring back its preferred worker to a new or modified job and notify its insurer within 90 days from the date of eligibility or the date of hire, whichever is later. Premium exemption starts on the date of hire or the date of eligibility, whichever is later.

(5) If a worker's preferred worker eligibility has not been determined as of the date of hire, the worker or the employer at injury or aggravation may request a preferred worker eligibility review. If the worker is eligible, the Workers' Compensation

Division will issue a Preferred Worker Identification Card to the worker. The employer must notify its insurer of the worker's preferred worker status within 90 days of the eligibility date on the preferred worker identification card. Premium exemption starts on the date of hire or the date of eligibility, whichever is later.

(6) If the employer is not the employer-at-injury or aggravation, the worker discloses preferred worker status to that employer, and the employer notifies the insurer within 90 days from the date of hire that they have hired a preferred worker, premium exemption starts on the date of hire.

(7) If a worker covered under premium exemption incurs a compensable injury or occupational disease during the premium exemption period, the employer must notify its insurer of the injury and the worker's preferred worker status. The claim costs for the injury are reimbursed under OAR 436-110-0330.

(8) If a business changes its name, is sold, merged, or otherwise changes its ownership during a premium exemption period, the premium exemption period is three years from the date the exemption was initiated by the original business. There will not be an additional three-year premium exemption period allowed due to the change(s) in the business.

(9) If an employer changes the job duties of a preferred worker during the premium exemption period, there is no change in the three year premium exemption period. There will not be an additional three-year premium exemption period allowed due to changes in the preferred worker's job duties with the same employer.

Stat. Auth.: ORS 656.726(4), 656.622; Stats. Implemented: ORS 656.622
Hist.: Amended 10-3-2012 as Admin. Order 12-058, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0330 Claim Cost Reimbursement

(1) Claim Cost Reimbursement provides reimbursement to the insurer for claim costs when a Preferred Worker files a claim for injury or occupational disease while employed under Premium Exemption as follows:

(a) Reimbursements will be made for the life of the claim;

(b) Reimbursable claim costs include disability benefits, medical benefits, vocational costs in accordance with OAR 436-120-0720, Claim Disposition Agreements in accordance with ORS 656.236, Disputed Claim Settlements in accordance with ORS 656.289, stipulations, as well as attorney fees awarded the worker or the worker's beneficiaries, and administrative costs;

(c) Reimbursable claim costs for denied claims include costs incurred up to the date of denial, but are limited to benefits the insurer is obligated to pay under ORS 656 and diagnostic tests, including independent medical examinations necessary to determine compensability of the claim;

(d) The administrative cost factor to be applied to claim costs will be as published in Bulletin 316; and

(e) The claim must not be used for ratemaking, individual employer rating, dividend calculations, or in any manner that would affect the employer's insurance premiums or premium assessments with the present or a future insurer. The insurer must be able to document that claim data will not affect the employer's rates or dividend.

(2) The insurer must request Claim Cost Reimbursement as follows:

(a) Requests for reimbursement must be made within one year of the end of the quarter within which payment was made;

(b) Quarterly reimbursement requests must be in the format the director prescribes by bulletin; and

(c) Reimbursement documentation must include, but is not limited to:

(A) Net amounts paid. "Net amounts" means the total compensation paid less any recoveries including, but not limited to, third party recovery or reimbursement from the Retroactive Program, Reopened Claims Program, or the fund;

(B) Payment certification statement; and

(C) Any other information the division deems necessary.

(3) Requests for reimbursement must not include:

(a) Claim costs for any injury that did not occur while the worker was employed with Premium Exemption;

(b) Costs incurred for conditions completely unrelated to the compensable claim;

(c) Costs incurred due to inaccurate, untimely, unreasonable, or improper processing of the claim;

(d) Penalties, fines or filing fees;

(e) Disposition amounts in accordance with ORS 656.236 (CDA) and 656.289 (DCS) not previously approved by the division;

(f) Costs reimbursed or outstanding requests for reimbursement from the Reopened Claims Program, Retroactive Program, or the fund; or

(g) Reimbursable Employer-at-Injury Program costs.

(4) Periodically, the division will audit the physical file of the insurer to validate the amount reimbursed. Reimbursed amounts must be refunded to the division and, as applicable, future reimbursements will be denied if, upon audit, any of the following is found to apply:

(a) Reimbursement has been made for any of the items specified in section (3) of this rule;

(b) If claim acceptance as a new injury rather than an aggravation is questionable and the rationale for acceptance has not been reasonably documented;

(c) The separate payments of compensation have not been documented;

(d) The insurer included claim costs in any dividend or retrospective rating or experience rating calculations;

(e) The insurer is unable to provide applicable records relating to experience rating, retrospective rating, or dividend calculations at the time of audit or within 14 working days thereafter.

(5) If the conditions described in subsections (4)(a) through (e) of this rule are corrected and all other criteria of the rules

are met, eligibility for reimbursement may be reinstated. If reimbursement eligibility is reinstated, any moneys previously reimbursed and then recovered will be reimbursed again according to these rules.

(6) A Claim Disposition Agreement according to ORS 656.236, a Disputed Claim Settlement according to ORS 656.289, or any stipulation or agreement of a claim subject to claim cost reimbursement from the fund must meet the following requirements for reimbursement:

(a) The insurer must obtain prior written approval of the disposition from the division. The proposed disposition must be submitted to the division prior to submitting the disposition to the Workers' Compensation Board or administrative law judge for approval;

(b) A claim's future liability and the proposed contribution from the fund must be a reasonable projection, as determined by the division, in order to be approved for reimbursement from the fund; and

(c) A request for approval of the proposed disposition must include:

(A) The original proposed disposition, containing appropriate signatures and appropriate signature lines for division and Workers' Compensation Board or administrative law judge approval, that specifies the proposed assistance from the fund;

(B) A written explanation of how the calculations for the amount of assistance from the fund were made; and

(C) Other information as required by the division.

Stat. Auth.: ORS 656.726(4), 656.622; Stats. Implemented: ORS 656.622
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-060, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0335 Wage Subsidy General Provisions

Wage subsidy provides an employer with partial reimbursement of a worker's gross wages for a specified period. Wage subsidy benefits are subject to the following conditions:

(1) The effective date of a *Wage Subsidy Agreement* is mutually agreed to by the division, employer, and worker if applicable;

(2) A wage subsidy is limited to a duration of 183 calendar days and a monthly reimbursement rate of 50 percent, except for a worker with an exceptional disability as defined in OAR 436-110-0005. For a worker with an exceptional disability, the wage subsidy duration is limited to 365 calendar days and a monthly reimbursement rate of 75 percent;

(3) A *Wage Subsidy Agreement* may be interrupted once for reasonable cause and extended to complete the *Wage Subsidy Agreement* on a whole workday basis. Reasonable cause includes, but is not limited to, personal or family illness, death in the worker's family, pregnancy of the worker or worker's spouse, a compensable injury to the worker, participation in an employer-at-injury program, or layoff. A layoff must be a minimum of 10 consecutive work days. A period of time during which the employer is without workers' compensation insurance coverage is not "reasonable cause," and no extension will be granted;

(4) A preferred worker's pay structure must be the same as the pay structure for other workers employed in similar jobs by the employer;

(5) Wages subject to reimbursement must be within the prevailing wage range for that occupation. The prevailing wage range is determined by the following method:

(a) First, examine the wages paid by the employer for other workers doing the same job;

(b) If no other workers are doing the same job, a labor market survey of the local labor market may be conducted; and

(c) If the labor market survey does not support the wage rate requested, the division will determine the wage subject to reimbursement;

(6) Preferred worker program wage subsidies may not be combined with a wage subsidy for a training plan under OAR 436-120;

(7) A worker-activated and employer at injury-activated wage subsidy can not be used for the same job with the employer at injury;

(8) If the worker's employer changes during the *Wage Subsidy Agreement* period due to a sale of the business, incorporation, or merger, the agreement can be transferred to the new employer by an addendum to the agreement approved by the division as long as the worker's job remains the same and the new employer is eligible under OAR 436-110-0310(1);

(9) A completed and signed *Wage Subsidy Reimbursement* Request form must be submitted to the division with a copy of the worker's payroll records. The payroll record must state the dates (daily or weekly), hours, wage rate, and the worker's gross wage. Payroll records must be a legible copy and compiled in accordance with generally accepted accounting procedures; and

(10) All requests for reimbursement must be made within one year of the *Wage Subsidy Agreement* end date.

(11) Wage subsidy cannot be used for "regular employment" as defined in OAR 436-110-0005 unless the job has been modified to overcome the worker's injury-caused permanent restrictions.

Stat. Auth.: ORS 656.726(4), 656.622; Stats. Implemented: ORS 656.622
Hist.: Amended 9-15-10 as WCD Admin. Order 10-055, eff. 10-12-10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0336 Wage Subsidy – Employer at Injury Activated

Wage subsidy may be activated by the employer at injury as follows:

(1) The job must be within the worker's injury-caused restrictions. If a worksite modification is necessary to meet this requirement, wage subsidy will be deferred until:

(a) The worksite modification is complete, or

(b) The employer accommodates the worker's injury-caused restrictions while waiting for the worksite modification to be complete.

(2) The employer must complete and sign a wage subsidy agreement, and send it to the division in the timeframes allowed in OAR 436-110-0290.

(3) The completed and signed job offer must accompany the request as required in OAR 436-110-0290(4), unless it was already submitted with another request.

(4) The employer at injury may use wage subsidy once during an eligibility period.

Stat. Auth.: ORS 656.726(4), 656.622; Stats. Implemented: ORS 656.622
Hist.: Amended 10-3-2012 as Admin. Order 12-058, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0337 Wage Subsidy – Worker Activated

A Wage Subsidy may be requested by a worker as follows:

(1) The worker and employer must complete and sign a *Wage Subsidy Agreement* and submit the agreement to the division within three years of the date of hire.

(2) A Preferred Worker may use Wage Subsidy twice, once each for two different jobs. The number of allowable uses will be restored if there is a subsequent claim closure, and the worker is unable to return to regular employment.

(3) If the employer at injury uses Wage Subsidy for a job, the worker cannot use Wage Subsidy for the same job.

Stat. Auth.: ORS 656.726(4), 656.622; Stats. Implemented: ORS 656.622
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-060, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0345 Employment Purchases – General Provisions

(1) An employment purchase is assistance necessary for a worker to find, accept, or retain employment in Oregon. These purchases may be provided for a job with a non-subject employer in Oregon, as long as that employer complies with the appropriate workers' compensation law. Employment purchases cannot be used for "regular employment" as defined in OAR 436-110-0005 unless the job has been modified to overcome the worker's injury-caused permanent restrictions. Except as provided in subsection (2)(h) of this rule, all purchases become the worker's property.

(2) Employment purchases are limited to:

(a) Tuition, books, and fees for instruction provided by an educational entity accredited or licensed by an appropriate body in order to update existing skills or to meet the requirements of an obtained job. Maximum expenditure per use is $1,000;

(b) Temporary lodging, meals, and mileage to attend instruction when overnight travel is required. The cost of meals, lodging, public transportation, and use of a personal vehicle will be reimbursed at the rate of reimbursement for State of Oregon classified employees as published in Bulletin 112. Lodging, meals, and mileage are limited to a combined period of one month, and the total maximum expenditure per use is $500;

(c) Tools and equipment mandatory for employment. Purchases must not include items the worker possesses, duplicate Worksite Modification items, vehicles, or items needed for worksite creation. Maximum expenditure per use is $2,500;

(d) Clothing required for the job. Maximum expenditure per use is $400;

(e) Moving expenses for a job if the new worksite is in Oregon and more than 50 miles from the worker's primary residence. When the worker's permanent disability from the injury precludes the worker from commuting the required distance, moving expenses may be provided to move within 50 miles of the worker's primary residence or within the distance the worker commuted for work at claim opening. Moving expenses are limited to one use. Expenditure is limited to:

(A) The cost of moving household goods weighing not more than 10,000 pounds and reasonable costs of meals and lodging for the worker. The cost of meals, lodging, public transportation, and use of a personal vehicle will be paid at the rate of reimbursement for State of Oregon classified employees as published in *Bulletin 112*. Lodging and meals are limited to a maximum period of two weeks. Mileage for one personal vehicle is limited to a single one-way trip; and

(B) Rental allowance for the worker's primary residence limited to first month's rent as specified in the rental agreement, non-refundable deposit in an amount not to exceed the first month's rent, and a required credit check for that residence;

(f) Initiation fees, or back dues and one month's current dues, required by a labor union;

(g) Occupational certification, licenses, and related testing costs, drug screen testing, physical examinations, or membership fees required for the job. Maximum expenditure is $500;

(h) Worksite creation costs that are limited to equipment, furnishings or other things the employer needs to create a new job for the worker. All items purchased are the property of the employer. Maximum expenditure per use is $5,000;

(i) Placement assistance requested by a preferred worker and provided by a certified vocational counselor or any public or private agency that provides placement services, that resulted in employment that the preferred worker retained for at least 90 days. This category can be used as often as necessary up to a maximum expenditure of $2000. Placement assistance may not be combined with vocational assistance under OAR 436-120; and

(j) Miscellaneous purchases that do not fit into subsections (a) through (i) of this section, subject to approval by the director. This category does not include a vehicle purchase. This category can be used as often as necessary up to a maximum of $2,500.

(3) The person or entity that purchased the item(s) may request reimbursement by submitting to the division a legible copy of an invoice or receipt showing payment has been made for the item(s) purchased. Reimbursement will be made for only those items and costs approved and paid.

(4) Costs of employment purchases will be paid by reimbursement, by an *Authorization for Payment*, or by other instrument of payment approved by the director.

(5) The division will not purchase directly or otherwise assume responsibility for employment purchases.

(6) Reimbursed costs will not be charged by the insurer to the employer as claim costs or by any other means.

(7) All requests for reimbursement must be made within one year of the *Employment Purchase Agreement* end date.

Stat. Auth.: ORS 656.726(4), 656.622; Stats. Implemented: ORS 656.622
Hist.: Amended 9-15-10 as WCD Admin. Order 10-055, eff. 10-12-10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0346 Employment Purchases – Employer at Injury Activated

Conditions for use of Employment Purchases by the employer at injury are as follows:

(1) The employer must submit a completed *Employment Purchase Agreement* listing item(s) that are required of the worker to perform the job for which the worker is employed.

(2) The employer at injury may use each Employment Purchase category once.

Stat. Auth.: ORS 656.726(4), 656.622; Stats. Implemented: ORS 656.622
Hist.: Amended 11/1/07 as WCD Admin. Order 07-066, eff. 12/1/07
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0347 Employment Purchases – Worker Activated

Conditions for use of employment purchases by a worker are as follows:

(1) Except for moving expenses, placement assistance, and miscellaneous purchases needed to find a job, the worker and employer must submit a completed employment purchase agreement listing item(s) that are required of the worker to obtain or perform the job.

(2) If employment purchases are to be used with a non-subject employer in Oregon, Premium Exemption is not activated.

(3) Except as otherwise provided in these rules, a preferred worker may use each employment purchase category twice, once each for two different jobs. The number of allowable uses will be restored if there is a subsequent claim closure, and the worker is unable to return to regular employment.

(4) A preferred worker may request employment purchases as follows:

(a) The worker must contact the division directly for assistance in receiving employment purchases. The worker may make the request prior to employment, but not more than three years after the date of hire.

(b) The employment purchase agreement form must be completed and signed by the worker and employer and submitted to the division. If the request is for moving expenses, placement assistance, or the miscellaneous category, only the worker's signature is required.

Stat. Auth.: ORS 656.726(4), 656.622; Stats. Implemented: ORS 656.622
Hist.: Amended 10-3-2012 as Admin. Order 12-058, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0350 Worksite Modification – General Provisions

(1) Worksite modification means altering a worksite in Oregon, or available for inspection and modification in Oregon, by purchasing, modifying, or supplementing equipment, or changing the work process, to enable a worker to work within the limitations imposed by compensable injuries or occupational diseases. Worksite modification may also include the means to protect modifications purchased by the preferred worker program in an amount not to exceed $2,500.

(2) Conditions for the use of worksite modification assistance are as follows:

(a) Modifications will be provided to allow the worker to perform the job duties within the worker's injury-caused permanent limitations. In order to determine appropriate worksite modifications, the reemployment assistance consultants have discretion to use reports by a medical service provider specific to the worker, specific documented "best practices" described by a medical service provider or authority, and their own professional judgment and experience;

(b) A job analysis that includes the duties and physical demands of the job before and after modification may be required to show how the modification will overcome the worker's limitations. The job analysis may be submitted to the attending physician for approval before the modification is performed;

(c) Modifications are limited to a maximum of $25,000 for one job. A modification over $25,000 may be provided if the worker has an exceptional disability as defined in OAR 436-110-0005;

(d) Modifications not to exceed $1,000 may be provided that would reasonably be expected to prevent further injury or exacerbation of the compensable injury or occupational disease, including any disability resulting from the compensable injury or occupational disease. A reemployment assistance consultant will determine the appropriateness of this type of modification based upon his or her professional judgment and experience, reports by a medical service provider specific to the worker, or specific documented "best practices" described by a medical service provider or authority. Costs of the modification(s) are included in the calculation of the total worksite modification costs;

(e) Modifications are limited to $2,500 for on-the-job training under OAR 436-120 or other similar on-the-job training programs when the trainer is not the employer at injury. A modification will not be approved for any other type of training;

(f) Modifications limited to $2,500 may be provided to protect the items approved in the *Worksite Modification Agreement* from theft, or damage from the weather. Insurance policy premiums will not be paid;

(g) When a vehicle is being modified, the vehicle owner must provide proof of ownership and insurance coverage. The worker must have a valid driver license;

(h) Rented or leased vehicles and other equipment will not be modified;

(i) Modifications must be reasonable, practical, and feasible, as determined by the division;

(j) When the division determines the appropriate form of modification and the worker or employer requests a form of modification equally appropriate but with a greater cost, upon division approval, funds equal to the cost of the form of modification identified by the division may be applied toward the cost of the modification desired by the worker or employer;

(k) A modification may include rental of tools, equipment, fixtures, or furnishings to determine the feasibility of a modification. It may also include consultative services necessary to determine the feasibility of a modification, or to recommend or design a worksite modification;

(l) Rental of worksite modification items and consultative services require division approval and are limited to a cost of up to $3,500 each. The cost for rental of worksite modification items and consultative services does not apply toward the total cost of a worksite modification;

(m) Modification equipment will become the property of the employer, worker, or worker leasing company's client on the "end date" of a *Worksite Modification Agreement* or when the worker's employment ends, whichever occurs first. The division will determine ownership of worksite modification equipment prior to approving an agreement and has the final authority to assign property;

(n) The division may request a physical capacities evaluation, work tolerance screening, or review of a job analysis to quantify the worker's injury-caused permanent limitations. The cost of temporary lodging, meals, public transportation, and use of a personal vehicle necessary for a worker to participate in one or more of these required activities will be reimbursed at the rate of reimbursement for State of Oregon classified employees as published in *Bulletin 112*. The cost of the services described in this subsection does not apply toward the total cost of a worksite modification;

(o) If the property provided for the modification is damaged, in need of repair, or lost, the division will not repair or replace the property;

(p) The employer must not dispose of the property provided for the modification or reassign it to another worker while the worker is employed in work for which the modification is necessary or prior to the end of the agreement without division and worker approval. Failure to repair or replace the property, or inappropriate disposal or reassignment of the property, may result in sanctions under OAR 436-110-0900; and

(q) The worker must not dispose of the property provided for the modification while employed in work for which the modification is necessary or prior to the end of the agreement without division approval. Failure to repair or replace the property, or inappropriate disposal of the property, may result in sanctions under OAR 436-110-0900.

(3) A worker, employer or their representative may request worksite modification assistance.

(4) The person or entity that purchased the item(s) may request reimbursement by submitting to the division proof of payment for the items purchased. Reimbursement will be made for only those items and costs approved and paid.

(5) Costs of approved worksite modifications are paid by reimbursement, an *Authorization for Payment*, or by other instrument of payment approved by the director.

(6) The division will not purchase directly or otherwise assume responsibility for worksite modifications.

(7) Reimbursed costs will not be charged by the insurer to the employer as claims costs or by any other means.

(8) A division worksite modification consultant will determine if competitive quotes are required.

(9) All requests for reimbursement must be made within one year of the *Worksite Modification Agreement* end date.

Stat. Auth.: ORS 656.726(4), 656.622; Stats. Implemented: ORS 656.622
Hist.: Amended 1/29/15 as WCD Admin. Order 15-055, eff. 3/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0351 Worksite Modification – Employer at Injury Activated

Conditions for use of Worksite Modifications by the employer at injury are as follows:

(1) The employer at injury may use worksite modification assistance once for a job provided for their injured worker, or a second time if the worker changes to another job with the employer at injury within the timeframes allowed in OAR 436-110-0290(2).

(2) Modifications are limited to a maximum of $25,000 on the claim which qualified the worker for assistance. A modification over $25,000 may be provided if the worker has an exceptional disability as defined in OAR 436-110-0005.

(3) The division must approve, by authorized signature, a completed and signed *Worksite Modification Agreement* prior to any reimbursement or *Authorization for Payment*.

(4) Modifications may be provided for requests received within 180 days from the worker's claim closure date. Additional modifications may be provided under an approved agreement by addendum for requests received within three years from the date the worker started work for the employer in employment for which the worksite modification request was made.

Stat. Auth.: ORS 656.726(4), 656.622; Stats. Implemented: ORS 656.622
Hist.: Amended 9-15-10 as WCD Admin. Order 10-055, eff. 10-12-10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0352 Worksite Modification – Worker Activated

Conditions for use of worksite modification assistance by the worker are as follows:

(1) The division must approve, by authorized signature, a completed and signed *Worksite Modification Agreement* form, prior to any reimbursement or *Authorization for Payment*.

(2) Modifications may be provided for requests received within three years from the date of hire.

(3) A worker may use worksite modification assistance once with one employer and once with a second employer, or twice with the same employer if there is a job change. The number of allowable uses will be restored if there is a subsequent claim closure, and the worker is unable to return to regular employment.

(4) Modifications after June 30, 1990, are limited to a maximum of $25,000 on the claim which qualified the worker for assistance. A modification over $25,000 may be provided for a worker with an exceptional disability as defined in OAR 436-110-0005. This maximum is not reduced by the use of worksite modifications by the employer at injury.

Stat. Auth.: ORS 656.726(4), 656.622; Stats. Implemented: ORS 656.622
Hist.: Amended 9-15-10 as WCD Admin. Order 10-055, eff. 10-12-10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0850 Audits

(1) Insurers and employers are subject to periodic program and fiscal audits by the division. All reimbursements are subject to subsequent audits, and may be disallowed on any of the grounds set forth in these rules. Disallowed reimbursements may be recovered by the division directly or from future reimbursements by way of offset. If the division finds upon audit that procedures which led to disallowed reimbursements are still being used, the division may withhold further reimbursements until corrections satisfactory to the division are made.

(2) An insurer or employer must maintain claim records, notices, worker payroll records, reports, receipts, and documentation of payment supporting reemployment assistance costs for which reimbursement has been requested or expenditure by *Authorization for Payment* has been made. These records must be maintained for a period of three years after the last reimbursement request or expenditure by *Authorization for Payment*.

(3) The division reserves the right to visit the worksite to determine compliance with the agreement under which reemployment assistance has been provided.

Stat. Auth.: ORS 656.455, 656.622, 656.726(4), 731.475
Stats. Implemented: ORS 656.455, 656.622, 731.475
Hist.: Amended 11/1/07 as WCD Admin. Order 07-066, eff. 12/1/07
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-110-0900 Sanctions

(1) Any person who knowingly makes any false statement or representation to the director or an employee of the director for the purpose of obtaining any benefit or payment from the Preferred Worker Program, or who knowingly misrepresents the amount of a payroll, or who knowingly submits a false payroll report, is subject to penalties under ORS 656.990.

(2) Reasons for the director to sanction an individual certified under OAR 436-120, a vocational assistance provider authorized under OAR 436-120, an agency of the State of Oregon, an insurer, an employer, or a Preferred Worker include, but are not limited to, the following:

(a) Misrepresenting information in order to obtain reemployment assistance. Two examples of misrepresentation are:

(A) Changing a job description or job title in order to obtain benefits where there are not corresponding job duty changes; and

(B) Obtaining a worker's signature on incomplete, incorrect, or blank agreements or reimbursement requests;

(b) Making a serious error or omission that resulted in the division approving a Preferred Worker Program Agreement, issuing a Preferred Worker card, or reimbursing claim costs in error;

(c) Failing to abide by the terms and conditions of a Preferred Worker Program Agreement;

(d) Failing to abide by the provisions of these rules or ORS 656.990;

(e) Failing to return required receipts or invoices;

(f) Submitting false reimbursement requests or job analyses;

(g) Altering an *Authorization for Payment* form or purchasing unauthorized items; or

(h) Failing to return a Preferred Worker card if requested by the division.

(3) Sanctions by the director may include one or more of the following:

(a) Ordering the person being sanctioned to repay the department for reemployment assistance costs incurred, including the department's legal costs;

(b) Prohibiting the person being sanctioned from negotiating or arranging reemployment assistance for such period of time as the director deems appropriate;

(c) Decertifying an individual or vocational assistance provider under the authority of OAR 436-120;

(d) Ordering an employer or worker ineligible for reemployment assistance for a specific period of time; and

(e) Pursuing civil or criminal action against the party.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622, 656.990
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-060, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 120

VOCATIONAL ASSISTANCE TO INJURED WORKERS

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436-120-0001 Authority for Rules

The director has adopted OAR 436-120 by the director's authority under ORS 656.340 and 656.726(4).

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impltd.: ORS 656.262(6), 656.268, 656.313, 656.331(1)(b), 656.340, 656.447, 656.740, 656.745, and ORS Ch. 183
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0002 Purpose of Rules

The purpose of these rules is to prescribe uniform standards for determining eligibility, delivery and payment for vocational services to injured workers, procedures for resolving disputes, and to establish standards for the certification of vocational counselors and providers.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impltd.: ORS 656.012(2)(c), 656.258, 656.268(1), 656.340
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0003 Applicability of Rules

(1) These rules govern vocational assistance under the workers' compensation law on or after the effective date of these rules except as OAR 436-120 otherwise provides.

(2) The director's decisions under OAR 436-120-0008 regarding eligibility will be based on the rules in effect on the date the insurer issued the notice. The director's decisions regarding the nature and extent of assistance will be based on the rules in effect at the time the assistance was provided. If the director orders future assistance, such assistance must be provided in accordance with the rules in effect at the time assistance is provided.

(3) Under these rules a claim for aggravation or reopening a claim to process a newly accepted condition will be considered

a new claim for purposes of vocational assistance eligibility and vocational assistance, except as otherwise provided in these rules.

(4) Under ORS 656.206, when a worker receiving permanent total disability incurs a new compensable injury, the worker is not entitled to vocational assistance.

(5) The requirement for the director's advance approval of services eligible for claims cost reimbursement pursuant to OAR 436-120-0720(7) will apply to any actions taken after the effective date of these rules.

(6) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(7) Timeliness of any document required by these rules to be filed or submitted to the division is determined as follows:

(a) If a document is mailed, it will be considered filed on the date it is postmarked.

(b) If a document is faxed or e-mailed, it must be received by the division by 11:59 p.m. Pacific time to be considered filed on that date.

(c) If a document is delivered, it must be delivered during regular business hours to be considered filed on that date.

(8) Time periods allowed for a filing or submission to the division are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impltd.: ORS 656.206, 656.340
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0005 Definitions

Except where the context requires otherwise, the construction of these rules is governed by the definitions given in the workers' compensation law and as follows:

(1) "Administrative approval" means approval of the director.

(2) "Authorized return to work plan" means a completed return-to-work plan form (Form 1081 for training or Form 1083 for direct employment), signed by the worker, the insurer, and the vocational counselor who developed the plan.

(3) "Cost-of-living matrix" is a chart issued annually by the director in Bulletin 124 that publishes the conversion factors, effective July 1 of each year, used to adjust for changes in the cost-of-living rate from the date of injury to the date of calculation. The conversion factor is based on the annual percentage increase or decrease in the average weekly wage, as defined in ORS 656.211.

(4) "Delivered" means physical delivery to the Workers' Compensation Division during regular business hours.

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

(6) "Division" refers to the Workers' Compensation Division of the Department of Consumer and Business Services.

(7) "Employer at injury" means an employer in whose employ the worker sustained the compensable injury or occupational disease.

(8) "Filed" means mailed, faxed, e-mailed, delivered, or otherwise submitted to the division in a method allowable under these rules.

(9) "Insurer" means the State Accident Insurance Fund, an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon, or a self-insured employer. A vocational assistance provider acting as the insurer's delegate may provide notices and warnings required by OAR 436-120.

(10) "Likely eligible" means the worker will be unable to return to regular or other suitable work with the employer-at-injury or aggravation or is unable to perform all of the duties of the regular or suitable work and it is reasonable to believe that the barriers are caused by the injury or aggravation.

(11) "Mailed" means postmarked to the last known address.

(12) "Permanent employment" is a job with no projected end date or a job that had no projected end date at time of hire. Permanent employment may be year-round or seasonal.

(13) "Physical demand characteristics of work" strength rating: The physical demands strength rating reflects the estimated overall strength requirements of the job, which are considered to be important for average, successful work performance. The following definitions are used: "occasionally" is an activity or condition that exists up to 1/3 of the time; "frequently" is an activity or condition that exists from 1/3 to 2/3 of the time; "constantly" is an activity or condition that exists 2/3 or more of the time.

(a) Sedentary work (S): Exerting up to 10 pounds of force occasionally or a negligible amount of force frequently to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

(b) Light work (L): Exerting up to 20 pounds of force occasionally, or up to 10 pounds of force frequently, or a negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for sedentary work. Even though the weight lifted may be only a negligible amount, a job should be rated light work: (1) when it requires walking or standing to a significant degree; (2) when it requires sitting most of the time but entails pushing or pulling of arm or leg controls; or (3) when the job requires working at a production rate pace entailing the constant pushing or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.

(c) Medium work (M): Exerting 20 to 50 pounds of force occasionally, or 10 to 25 pounds of force frequently, or greater than negligible up to 10 pounds of force constantly to move objects. Physical demand requirements are in excess of those for light work.

(d) Heavy work (H): Exerting 50 to 100 pounds of force occasionally, or 25 to 50 pounds of force frequently, or 10 to 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for medium work.

(e) Very heavy (VH): Exerting in excess of 100 pounds of force occasionally, or in excess of 50 pounds of force frequently, or in excess of 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for heavy work.

(14) "Reasonable cause" may include, but is not limited to, a medically documented limitation in a worker's activities due to illness or medical condition of the worker or the worker's family, financial hardship, incarceration for less than six months, or circumstances beyond the reasonable control of the worker. "Reasonable cause" for failure to provide information or participate in activities related to vocational assistance will be determined based upon individual circumstances of the case.

(15) "Reasonable labor market": An occupation can be said to have reasonable employment opportunities if competitively qualified workers can expect to find equivalent jobs in the occupation within a reasonable period of time. A reasonable period of time, for workers in the majority of occupations, would be the six months that they could collect regular unemployment insurance benefits, if they were entitled to them.

(16) "Regular employment" means the employment the worker held at the time of the injury or at the time of the claim for aggravation, whichever gave rise to the potential eligibility for vocational assistance; or, for a worker not employed at the time of aggravation, the employment the worker held on the last day of work prior to the aggravation claim. If the basis for potential eligibility is a reopening to process a newly accepted condition, "regular employment" is the employment the worker held at the time of the injury; when the condition arose after claim closure, "regular employment" is determined as if it were an aggravation claim.

(17) "Substantial handicap to employment," as determined under OAR 436-120-0340, means the worker, because of the injury or aggravation, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in suitable employment. "Knowledge," "skills," and "abilities" have meanings as follows:

(a) "Knowledge" means an organized body of factual or procedural information derived from the worker's education, training, and experience.

(b) "Skills" means the demonstrated mental and physical proficiency to apply knowledge.

(c) "Abilities" means the cognitive, psychological, and physical capability to apply the worker's knowledge and skills.

(18) "Suitable employment" or "suitable job" means employment or a job:

(a) For which the worker has the necessary physical capacities, knowledge, skills and abilities;

(b) Located where the worker customarily worked, or within reasonable commuting distance of the worker's residence. A reasonable commuting distance is no more than 50 miles one-way modified by other factors including, but not limited to:

(A) Wage of the job. A low wage may justify a shorter commute;

(B) The pre-injury commute;

(C) The worker's physical capacities, if they restrict the worker's ability to sit or drive for 50 miles;

(D) Commuting practices of other workers who live in the same geographic area; and

(E) The distance from the worker's residence to the nearest cities or towns that offer employment opportunities;

(c) That pays or would average on a year-round basis a suitable wage as defined in section (19) of this rule;

(d) That is permanent. Temporary work is suitable if the worker's job at injury was temporary; and the worker has transferable skills to earn, on a year-round basis, a suitable wage as defined in section (19) of this rule;

(e) For which a reasonable labor market as described under OAR 436-120-0340 is documented to exist; and

(f) That is modified or new employment resulting from an employer at injury activated use of the Preferred Worker Program, under OAR 436-110:

(A) Nine months from the effective date of the premium exemption if there are no worksite modifications, or

(B) Twelve months from the date the department determines the worksite modification is complete, or

(C) If the worker is terminated for cause, or

(D) If the worker voluntarily resigns for a reason unrelated to the work injury.

(19) "Suitable wage" means:

(a) For the purpose of determining eligibility for vocational assistance, a wage at least 80 percent of the adjusted weekly wage as defined in OAR 436-120-0007.

(b) For the purpose of providing or ending vocational assistance, a wage as close as possible to 100 percent of the adjusted weekly wage. This wage may be considered suitable if less than 80 percent of the adjusted weekly wage, if the wage is as close as possible to the adjusted weekly wage.

(20) "Training" means a vocational rehabilitation service provided to a worker who is enrolled and actively engaged in an approved "Return-to-Work Plan; Training" as documented on Form 1081.

(21) "Transferable skills" means the knowledge and skills demonstrated in past training or employment that make a

worker employable in suitable new employment. More general characteristics such as aptitudes or interests do not, by themselves, constitute transferable skills.

(22) "Vocational assistance" means any of the services, goods, allowances, and temporary disability compensation under these rules to assist an eligible worker return to work. This does not include activities for determining a worker's eligibility for vocational assistance.

(23) "Vocational assistance provider" means an insurer or other public or private organization, registered under these rules to provide vocational assistance to injured workers.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Sta. Impltd.: ORS 656.340
Hist.: Amended 1/29/15 as Admin. Order 15-056, eff. 3/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0006 Administration of Rules

(1) At any time, the director may order the insurer to determine eligibility or provide specified vocational assistance to achieve compliance with ORS chapter 656 and these rules. The order may be appealed as provided by statute.

(2) Orders issued by the division in carrying out the director's authority to administer and to enforce ORS chapter 656 and these rules are considered orders of the director.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impltd.: ORS 656.313, 636.340
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0007 Establishing the Adjusted Weekly Wage to Determine Suitable Wage

To determine a suitable wage as defined in OAR 436-120-0005 the insurer must first establish the adjusted weekly wage as described in this rule. The insurer must calculate the "adjusted weekly wage" whenever determining or redetermining a worker's eligibility.

(1) For the purposes of this rule, the following definitions apply:

(a) "Adjusted weekly wage" is the wage currently paid as calculated under this rule.

(b) "Cost-of-living adjustments" or "collective bargaining adjustments" are increases or decreases in the wages of all workers performing the same or similar jobs for a specific employer. These adjustments are not variations in wages based on skills, merit, seniority, length of employment, or number of hours worked.

(c) "Earned income" means gross wages, salary, tips, commissions, incentive pay, bonuses, and the reasonable value of other consideration (housing, utilities, food, etc.) received from all employers for services performed from all jobs held at the time of injury or aggravation. Earned income also means gross earnings from self- employment after deductions of business expenses excluding depreciation. Earned income does not include fringe benefits such as medical, life or disability insurance, employer contributions to pension plans, or reimbursement of the worker's employment expenses such as mileage or equipment rental.

(d) "Job at aggravation" means the job or jobs the worker held on the date of the aggravation claim; or, for a worker not employed at time of aggravation, the last job or concurrent jobs held prior to the aggravation. Volunteer work does not constitute a job for purposes of this subsection.

(e) "Job at injury" is the job on which the worker originally sustained the compensable injury. For an occupational disease, the job at injury is the job the worker held at the time there is medical verification that the worker is unable to work because of the disability caused by the occupational disease.

(f) "Permanent, year-round employment" is permanent employment in which the worker worked or was scheduled or projected to work in 48 or more calendar weeks a year. Paid leave is counted as work time. Permanent year-round employment includes trial service. It does not include employment with an annual salary set by contract or self-employment.

(g) "Temporary disability" means wage loss replacement for the job at injury.

(h) "Trial service" is employment designed to lead automatically to permanent, year-round employment subject only to the employee's satisfactory performance during the trial service period.

(2) The insurer must determine the nature of the job at injury or the job or jobs at aggravation by contacting the employer or employers to verify the worker's employment status. All figures used in determining a weekly wage by this method must be supported by verifiable documentation such as the worker's state or federal tax returns, payroll records, or reports of earnings or unemployment insurance payments from the Employment Department. The insurer must calculate the worker's adjusted weekly wage as described by this rule.

(3) When the job at injury or the job at aggravation was temporary or seasonal, calculate the worker's average weekly wage as follows, then convert to the adjusted weekly wage as described in section (6) of this rule:

(a) When the worker's regular employment is the job at injury and the worker did not hold more than one job at the time of injury, and did not receive unemployment insurance benefits during the 52 weeks prior to the injury, the worker's average weekly wage is the same as the wage upon which temporary disability is based.

(b) When the worker's regular employment is the job at aggravation and the worker did not hold more than one job at the time of aggravation, and did not receive unemployment insurance benefits during the 52 weeks prior to the aggravation, the worker's average weekly wage is calculated using the same methods used to calculate temporary disability as described in OAR 436-060-0025.

(c) If the worker held more than one job at the time of the injury or aggravation, and did not receive unemployment insurance payments during the 52 weeks prior to the date of the injury or aggravation, divide the worker's earned income

by the number of weeks the worker worked during the 52 weeks prior to the date of injury or aggravation.

(d) If the worker held one or more jobs at the time of the injury or aggravation, and received unemployment insurance payments during the 52 weeks prior to the date of the injury or aggravation, combine the earned income with the unemployment insurance payments and divide the total by the number of weeks the worker worked and received unemployment insurance payments during the 52 weeks prior to the date of the injury or aggravation.

(4) When the job at injury was other than as described in section (3) of this rule, use the weekly wage upon which temporary disability was based, and then convert the weekly wage to the adjusted weekly wage as described in section (6) of this rule.

(5) When the job at aggravation was other than as described in section (3) of this rule, the worker's average weekly wage is calculated using the same methods used to calculate temporary disability as described in OAR 436-060-0025, and then converting to the adjusted weekly wage as described in section (6) of this rule.

(6) Adjusted weekly wage: After arriving at the weekly wage under this rule, establish the adjusted weekly wage by determining the percentage increase or decrease from the date of injury or aggravation, or last day worked prior to aggravation, to the date of calculation, as follows:

(a) Contact the employer at injury regarding any cost-of-living or collective bargaining adjustments for workers performing the same job. Adjust the worker's weekly wage by any percentage increase or decrease;

(b) If the employer at injury is no longer in business and the worker's job was covered by a union contract, contact the applicable union for any cost-of-living or collective bargaining adjustments. Adjust the worker's weekly wage by the percentage increase or decrease;

(c) If the employer at injury is no longer in business or does not currently employ workers in the same job category, adjust the worker's weekly wage by the appropriate factor from the cost-of-living matrix; or

(d) If the worker's regular employment was the employment the worker held at the time of aggravation, adjust the worker's weekly wage by the appropriate factor from the cost-of-living matrix.

Stat. Auth.: ORS 656.340(9), ORS 656.726(4)
Stat. Impltd.: ORS 656.340(5) and (6)
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0008 Administrative Review and Contested Cases

(1) Administrative review of vocational assistance matters: Under ORS 656.340(16), a worker wanting review of any vocational assistance matter must apply to the director for administrative review. Also, under ORS 656.340(11) and OAR 436-120-0185(1) when the worker and insurer are unable to agree on a vocational assistance provider, the insurer must apply to the director for administrative review. Because effective vocational assistance is best realized in a nonadversarial environment, the first objective of the administrative review is to bring the parties to resolution through alternative dispute resolution procedures, including mediation conferences, whenever possible and appropriate. When a dispute is not resolved through mutual agreement or dismissal, the director will close the record and issue a Director's Review and Order as described in subsections (f) and (g) of this section. A worker need not be represented to request or to participate in the administrative review process, which is as follows:

(a) The worker's request for review must be mailed or otherwise communicated to the department no later than the 60th day after the date the worker received written notice of the insurer's action; or, if the worker was represented at the time of the notice, within 60 days of the date the worker's representative received actual notice. Issues raised by the worker where written notice was not provided may be reviewed at the director's discretion.

(b) The worker, insurer, employer at injury, and vocational assistance provider must supply needed information, attend conferences and meetings, and participate in the administrative review process as required by the director. Upon the director's request, any party to the dispute must provide available information within 14 days of the request. The insurer must promptly schedule, pay for, and submit to the director any medical or vocational tests, consultations, or reports required by the director. The worker, insurer, employer at injury, or vocational assistance provider must simultaneously send copies to the other parties to the dispute when sending material to the director. If necessary, the director will assist an unrepresented worker in sending copies to the appropriate parties. Failure to comply with this subsection may result in the following:

(A) If the worker fails to comply without reasonable cause, the director may dismiss the administrative review as described in subsection (d); or, the director may decide the issue on the basis of available information.

(B) If the insurer, vocational assistance provider, or employer at injury fails to comply without reasonable cause, the director may decide the issue on the basis of available information.

(c) At the director's discretion, the director may issue an order of deferral to temporarily suspend administrative review. The order of deferral will specify the conditions under which the review will be resumed.

(d) The director may issue an order of dismissal under appropriate conditions.

(e) The director will issue a letter of agreement when the parties resolve a dispute within the scope of these rules. Any agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney. The agreement will become effective on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may reconsider approval

of the agreement upon the director's own motion or upon a motion by a party. The director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) One or both parties fail to honor the agreement;

(B) The agreement was based on misrepresentation;

(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or

(D) All parties request revision or reinstatement of the review.

(f) After the parties have had the opportunity to present evidence, and any meetings or conferences deemed necessary by the director have been held, the director will issue a final order. The parties have 60 days from the date the order is issued to request a hearing. An order is issued on the date it is mailed.

(g) The director may on the director's own motion reconsider or withdraw any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new material evidence that could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request for reconsideration must be mailed before the administrative order becomes final, or if appealed, before the proposed and final order is issued.

(h) During any reconsideration of the administrative review order, the parties may submit new material evidence consistent with this rule and may respond to such evidence submitted by others.

(i) Any party requesting reconsideration or responding to a reconsideration request must simultaneously notify all other interested parties of their contentions and provide them with copies of all additional information presented.

(j) A request for reconsideration does not stay the 60-day time period within which the parties may request a hearing.

(2) Attorney fees will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 to 436-001-0440.

(3) Hearings before an administrative law judge:

(a) Under ORS 656.340(16) and 656.704(2), any party that disagrees with an order issued under subsection (1)(f) of this rule or a dismissal issued under subsection (1)(d) of this rule may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(b) Under ORS 656.704(2), any party that disagrees with an order of dismissal based on lack of jurisdiction under subsection (1)(d) of this rule or department denial of reimbursement for vocational assistance costs may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days after the party received the dismissal or written denial.

(c) Under ORS 656.704(2), an insurer sanctioned under OAR 436-120-0900, a vocational assistance provider or certified individual sanctioned under ORS 656.340(9) and OAR 436-120-0915, a vocational assistance provider denied registration under ORS 656.340(9)(a) and OAR 436-120-0800, or an individual denied certification under ORS 656.340(9)(a) and OAR 436-120-0810 may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 no later than 60 days after the party received notification of the action.

(d) OAR 436-001 applies to the hearing.

(4) Contested case hearings of civil penalties: Under ORS 656.740 an insurer or an employer may appeal a proposed order or proposed assessment of civil penalty under ORS 656.745 and OAR 436-120-0900 as follows:

(a) The insurer or employer must send the request for hearing in writing to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The party must file the request with the division within 60 days after the mailing date of the notice of the proposed order or assessment.

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

(d) The Hearings Division will conduct the hearing in accordance with ORS 656.740 and ORS chapter 183.

Stat. Auth.: ORS 656.704(2), 656.726(4)
Stats. Implemented: ORS 656.704, 656.283(2), 656.340, 656.447, 656.740, 656.745
Hist.: Amended 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0012 General Requirements For Notices and Warnings

(1) All notices and warnings to the worker issued under OAR 436-120 must:

(a) Be in writing, signed, and dated.

(b) State the basis for the decision.

(c) Include the effective date of each action in the heading.

(d) Cite the relevant rule(s).

(e) Include the worker's appeal rights. All notices and warnings except those notifying a worker of entitlement to training or deferral of vocational assistance eligibility must contain the worker's appeal rights in bold type, as follows:

"If you disagree with this decision, you should contact (insert the person's name and the insurer name) within five days of receiving this letter to discuss your concerns. If you are still dissatisfied, you must contact the Workers' Compensation Division within 60 days of receiving this letter or you will lose your right to appeal this decision. A consultant with the division can talk with you about the disagreement and, if necessary, will review your appeal. The address and telephone number of the division are: Employment Services Team, Workers' Compensation Division, P.O. Box 14480, Salem, Oregon 97309-0405; 503-947-7816 or 1-800-452-0288 ext. 1719."

(f) Include the telephone number of the Ombudsman for Injured Workers: 1-800-927-1271; and

(g) Be mailed to the worker by both regular and certified mail.

(2) All copies of notices must be mailed to the worker's legal representative. Failure to send a copy to the worker's legal representative stays the appeal period until the worker's legal representative receives a copy of the notice.

(3) Unless otherwise indicated under OAR 436-120-0017, copies of all notices must be mailed to the division at the same time they are mailed to the worker.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impltd.: ORS 656.340
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0014 Notification of Employment and Reinstatement Rights and Responsibilities

(1) The insurer must inform a worker with a compensable injury of the employment reinstatement rights and responsibilities under ORS chapter 659A and this rule:

(a) When the claim is accepted under ORS 656.262(6);

(b) When the insurer contacts the worker under OAR 436-120-0115 about the need for vocational assistance under ORS 656.340(2); and

(c) Within five days of receiving notification that the attending physician has released the worker to go back to work, under ORS 656.340(3).

(2) The insurer must inform the employer about the worker's reemployment rights within five days of receiving notification of the attending physician's release of the worker to return to work, under ORS 656.340(3).

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended and renumbered from OAR 436-120-0004, 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0016 Warning Letters

(1) A warning letter can be issued at any time during the vocational eligibility evaluation or vocational assistance process.

(2) Warning letters do not require specific language in the headings but must include a heading clearly indicating the purpose of the warning.

(3) A warning letter must state what the worker must do, and by when, to avoid ineligibility or the ending of eligibility or training.

(4) A warning letter must include the worker's appeal rights under OAR 436-120-0012(1)(e).

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impltd.: ORS 656.340
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0017 Types of Notices

When the insurer takes any of the actions listed below, it must issue the corresponding notices, using the headings listed in this rule. If a notice is used for more than one purpose, it must include all the headings that apply:

(1) The **NOTICE OF ELIGIBILITY** must:

(a) Include the date the worker became eligible.

(b) Inform the worker which category of vocational assistance the insurer will provide:

(A) **NOTICE OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE and NOTICE OF ENTITLEMENT TO TRAINING**, or

(B) **NOTICE OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE and NOTICE OF ENTITLEMENT TO DIRECT EMPLOYMENT SERVICES**.

(c) Include the worker's rights and responsibilities;

(d) Include the following statement in bold type:

"You have the right to request a return-to-work plan conference if the insurer does not approve a return-to-work plan within 90 days of determining you entitled to a training plan, or within 45 days of determining you entitled to a direct employment plan. The purpose of the conference will be to identify and remove all obstacles to return-to-work plan completion and approval. The insurer, the worker, the plan developer, and any other parties involved in the return-to-work process must attend the conference. The insurer or the worker may request a conference with the division if other delays in the vocational rehabilitation process occur. Your request for this conference should be directed to the Employment Services Team of the Workers' Compensation Division. The address and telephone number of the division are: Employment Services Team, Workers' Compensation Division, P.O. Box 14480, Salem, Oregon 97309-0405; 503-947-7816 or 1-800-452-0288 ext. 1719."

(e) Include the current list of vocational assistance providers (published with Bulletin 151), and explain that the worker and the insurer must agree on the selection of a vocational assistance provider.

(f) Include the following language in bold type:

"If you have questions about the vocational counselor selection process, contact (use appropriate reference to the insurer). If you still have questions, call the Workers' Compensation Division at 1-800-452-0288 ext. 1719."

(g) Include information about the Preferred Worker Program.

(h) Explain what the worker can do if he or she disagrees with something the insurer does.

(i) Explain direct employment services and state the worker is not entitled to training, if the worker is entitled to direct employment services but not training.

(2) The **NOTICE OF INELIGIBILITY FOR VOCATIONAL ASSISTANCE** must:

(a) Include information about services which may be available at no cost from the Employment Department or the Office of Vocational Rehabilitation Services.

(b) Include a brief description of the Preferred Worker Program benefits, and contact information. The information can be part of the notice, or a separate document attached to the notice.

(c) Include a list of suitable occupations the worker can perform without being retrained, if the notice is based on a finding of "no substantial handicap."

(3) The **NOTICE OF DEFERRAL OF VOCATIONAL ASSISTANCE ELIGIBILITY DETERMINATION** must:

(a) Inform the worker the insurer deferred the vocational eligibility process because the employer at injury has activated preferred worker benefits.

(b) Inform the worker that, if the job with the employer at injury does not begin on the hire date listed in the job offer letter, the worker can ask the insurer, within 30 days, to determine vocational eligibility.

(c) Include the following language in bold type:

"If you have questions about the deferral of the vocational eligibility process, contact (use appropriate reference to the insurer). If you still have questions contact the Workers' Compensation Division's toll free number 1-800-452-0288 ext. 1719."

(4) The **NOTICE OF DENIAL OF VOCATIONAL ASSISTANCE BENEFITS** must:

(a) Identify what vocational assistance benefits the insurer denies and explain why. This notice is not to be used for finding a worker ineligible or ending a worker's eligibility for vocational assistance.

(b) Explain why the insurer denies the proposed return-to-work plan, if the notice is used for that purpose.

(5) The **NOTICE OF END OF TRAINING**:

(a) Must include the date the training plan ended. The effective date is the worker's last date of attendance.

(b) Must state whether the worker is entitled to further training.

(c) Does not have to be submitted to the division.

(6) The **NOTICE OF END OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE**:

(a) Must include the date when eligibility ended. The effective date is the worker's last date of eligibility.

(b) Must include the reason the worker's eligibility for vocational assistance is ending. However, this notice is not required if the insurer is ending the worker's eligibility because the worker has given up his or her vocational assistance rights through a claims disposition agreement.

(c) Does not have to be submitted to the division.

(7) The **NOTICE OF SELECTION OF VOCATIONAL ASSISTANCE PROVIDER**, must be issued when a vocational assistance provider is agreed upon by the worker and the insurer.

(8) The **NOTICE OF CHANGE OF VOCATIONAL ASSISTANCE PROVIDER**, must be issued anytime there is a change in vocational assistance provider.

(9) The return-to-work plan and amendments must:

(a) Be reported using Form 1081, Return-to-Work Plan, Training, or Form 1083 Return-to-Work Plan, Direct Employment.

(b) Indicate what the changes are and why they are necessary, if the insurer amends the proposed plan.

(10) The Vocational Closure Report (Form 2800) must:

(a) Include the effective date for the end of eligibility.

(b) Include the reason for the end of eligibility.

(c) Include return-to-work and vocational assistance provider information.

(d) Be issued for each eligible worker within 30 days after eligibility ends.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impltd.: ORS 656.340
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0018 Postponement Notices

A letter informing the worker that the eligibility evaluation has been postponed does not require specific language in the headings but must include a heading clearly indicating the purpose of the letter and must:

(1) Explain the reason the worker's eligibility evaluation is postponed.

(2) Explain to the worker in writing what information is necessary if the insurer cannot complete the vocational eligibility process because it needs more information. In that case, the insurer must state when it expects to determine eligibility or make a decision.

(3) Explain, if the worker has accepted a job offer from the employer at injury, that if the job does not begin on the hire date listed in the job offer letter, the worker can ask the insurer within 30 days to determine vocational eligibility.

(4) Be mailed to the worker within 14 days of the insurer receiving notification that the worker is likely eligible for vocational assistance.

(5) Include the following language in bold type:

"If you have questions about the postponement of the vocational eligibility process, contact (use appropriate reference to the insurer). If you still have questions contact the Workers' Compensation Division's toll free number 1-800-452-0288 ext. 1719."

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended and renumbered from OAR 436-120-0004, 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0115 Conditions Requiring Completion of a Vocational Eligibility Evaluation

(1) If the worker has an accepted disabling claim, the insurer is required to begin an eligibility evaluation within five days of any of the following conditions:

(a) The insurer receives information that indicates the worker is likely eligible for vocational assistance;

(b) The worker is medically stationary, is not currently receiving vocational assistance, and:

(A) Has not returned to or been released to regular employment; or

(B) Has not returned to other suitable employment with the employer at the time of injury or aggravation.

(c) The worker enters into a claim disposition agreement, retains vocational assistance rights, and is likely eligible for vocational assistance; or

(d) Eligibility was previously determined under the current opening of the claim and the insurer has accepted new condition(s).

(2) Even if conditions in (1) are met, the insurer is not required to do an eligibility evaluation if the worker is deceased, the worker has a permanent total disability award, or the worker's claim is reopened under a board's own motion.

(3) Nothing in these rules prevents an insurer from finding a worker eligible and providing vocational assistance at any time.

(4) If the insurer receives a request for vocational assistance from the worker and the insurer is not required to determine eligibility, the insurer must notify the worker in writing, within 14 days of the request. The notice must include at least:

(a) The reason(s) an eligibility determination is not required;

(b) The circumstances that, if present, would trigger a requirement to determine eligibility; and

(c) Instructions to contact the division at 503-947-7816 or 1-800-452-0288 ext. 1719 with questions about vocational assistance eligibility requirements and procedures.

(5) The insurer must determine eligibility if the worker's claim was initially denied and is later accepted as disabling and all appeals of the denial have been exhausted.

Stat. Auth.: ORS 656.340, ORS 656.726(4)
Stat. Impltd.: ORS 656.340
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0125 Conditions for Postponement of the Vocational Eligibility Evaluation

(1) If the worker requested an eligibility evaluation but the insurer does not know the worker's permanent limitations, the insurer may postpone the evaluation until the worker's permanent restrictions are known or can be projected. In that case, within 14 days of receiving the worker's request the insurer must contact the attending physician to ask if permanent limitations are known or can be projected. The insurer must also notify the worker in writing that the determination will be postponed until permanent restrictions are known or can be projected.

(2) If the claim qualifies for closure under ORS 656.268(1)(b) or (c), the insurer may postpone the determination until the worker is medically stationary or until permanent restrictions are known or can be projected, whichever occurs first.

(3) If the insurer is unable to determine eligibility or make a decision regarding a particular vocational service because of insufficient data, the insurer must explain to the worker in writing what information is necessary and when it expects to determine eligibility or make a decision. This explanation must be mailed to the worker within 14 days of the insurer receiving notification that the worker is likely eligible for vocational assistance.

Stat. Auth.: ORS 656.340, ORS 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended and renumbered 12-1-2009 from OAR 436-120-0320 as WCD Admin. Order 09-061, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0135 General Requirements and Timeframes for Vocational Eligibility Evaluations

(1) When an eligibility evaluation is required, the insurer must contact the worker to start the eligibility determination process within 5 days of the date the insurer received knowledge of likely eligibility.

(2) A certified vocational counselor must determine vocational eligibility and the insurer must provide the vocational counselor with all existing relevant medical information.

(3) At the insurer's request, the worker must provide vocationally relevant information needed to determine eligibility within a reasonable time set by the insurer.

(4) The insurer must complete the eligibility determination within 30 days of the date the insurer initiated contact with the worker under subsection (1) of this rule, unless postponed under OAR 436-120-0125.

(5) If the eligibility determination is postponed, the eligibility evaluation must be completed within 30 days of the insurer's receipt of requested relevant information.

(6) Either the insurer or certified vocational counselor may issue the notice with the results of the eligibility evaluation to the worker.

(7) Vocational assistance will only be provided for one claim at a time, unless the parties agree otherwise. If the worker is eligible for vocational assistance under two or more claims, the claim for the injury with the most severe vocational impact is the claim that gave rise to the need for vocational assistance. The parties may agree to provide services for more than one claim at a time, and extend time and fee limits beyond those allowable in these rules.

Stat. Auth.: ORS 656.340, ORS 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended and renumbered 12-1-2009 from OAR 436-120-0320 as WCD Admin. Order 09-061, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0145 Vocational Assistance Eligibility Criteria

(1) A worker whose permanent total disability benefits have been terminated by a final order is eligible for vocational assistance.

(2) A worker is eligible for vocational assistance if all the following conditions are met:

(a) The worker is authorized to work in the United States.

(b) The worker is available for vocational assistance in Oregon or within commuting distance of Oregon.

(A) If the worker is not available in Oregon or within commuting distance of Oregon, the insurer must consider the worker available in Oregon if the worker states in writing that within 30 days of being determined eligible for vocational assistance the worker will move back to Oregon, or to within commuting distance of Oregon, at the worker's own expense.

(B) The requirement that the worker be available in Oregon or within commuting distance of Oregon for vocational assistance does not apply if the Oregon subject worker did not work and live in Oregon at the time of the injury.

(c) As a result of the limitations caused by the injury or aggravation, the worker:

(A) Is not able to return to regular employment;

(B) Is not able to return to suitable and available work with the employer at injury or aggravation; and

(C) Has a substantial handicap to employment and requires assistance to overcome that handicap.

(d) The worker was not employed in suitable employment for at least 60 days after the injury or aggravation.

(e) The worker did not refuse or fail to make a reasonable effort in available light-duty work intended to result in suitable employment. Prior to finding the worker ineligible, the insurer must document the existence of one or more suitable jobs that would be available for the worker after completion of the light-duty work. If the employer-at-injury offers such employment to a non-medically stationary worker, the offer must be made in accordance with OAR 436-060.

(f) The worker is available for vocational assistance. If the worker is not available, the insurer must determine if the reasons are for reasonable or unreasonable cause prior to ending the worker's eligibility. If the reason was for incarceration, this reason must be cited in the notice to the worker. Declining vocational assistance to accept modified or new employment that results from an employer-at-injury activated use of the Preferred Worker Program, under OAR 436-110, is reasonable cause.

(g) The worker did not refuse or otherwise relinquish his or her rights to vocational assistance in writing.

(3) The worker must participate in the vocational assistance process and must provide relevant information. If the worker does not participate, or fails to provide relevant information, the insurer must issue a written warning before finding the worker ineligible under this rule.

(4) The worker must not misrepresent a matter material to evaluating eligibility.

Stat. Auth.: ORS 656.340, ORS 656.726(4)
Stat. Impltd.: ORS 656.206, 656.340
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0155 Deferral and Completion of an Eligibility Evaluation When the Employer Activates Preferred Worker Program Benefits:

(1) The insurer must defer the determination of vocational assistance eligibility when the employer at injury activates preferred worker benefits under OAR 436-110 and the worker agrees in writing to accept the new or modified regular job. All of the following conditions must exist:

(a) The employer must make a written job offer to the worker that includes the following information:

(A) The start date;

(B) Wage and hours;

(C) Job site location;

(D) Description of job duties; and

(E) A statement that the job does not begin until the modifications are in place.

(b) The insurer must send the worker a Notice of Deferral of Vocational Assistance Eligibility Determination within 14 days of the date the worker signed the job offer letter indicating acceptance of the job.

(2) The insurer must complete the eligibility evaluation within 30 days of a determination that preferred worker benefits will not be provided or if the agreement is terminated.

Stat. Auth.: ORS 656.340, ORS 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended and renumbered 12-1-2009 from OAR 436-120-0320 as WCD Admin. Order 09-061, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0165 End of Eligibility for Vocational Assistance

A worker's eligibility ends when any of the following conditions apply:

(1) Based on new information that did not exist or that could not have been obtained with reasonable effort at the time the insurer determined eligibility, the worker no longer meets the eligibility requirements.

(2) The worker has been employed in suitable employment as described in OAR 436-120-0005(18) for at least 60 days after the date of injury or date of aggravation, and any necessary worksite modification is in place.

(3) The worker, prior to beginning an authorized return-to-work plan, refused an offer of suitable employment. If the employer-at-injury offers employment to a non-medically stationary worker, the offer must be made in accordance with OAR 436-060.

(4) The worker, prior to beginning an authorized return-to-work plan, left suitable employment after the injury or aggravation for a reason unrelated to the limitations caused by the injury.

(5) The worker, prior to beginning an authorized return-to-work plan, refused or failed to make a reasonable effort in available light-duty work intended to result in suitable employment. Prior to ending eligibility, the insurer must document the existence of one or more suitable jobs that would

be available for the worker after completion of the light-duty work. If the employer-at-injury offers such employment to a non-medically stationary worker, the offer must be made in accordance with OAR 436-060.

(6) The worker, after completing an authorized training plan, refused an offer of suitable employment.

(7) The worker declined or became unavailable for vocational assistance. The insurer must determine if the reasons are for reasonable or unreasonable cause prior to ending the worker's eligibility. If the reason was for incarceration, this reason must be cited in the notice to the worker. Declining vocational assistance to accept modified or new employment that results from an employer-at-injury activated use of the Preferred Worker Program, under OAR 436-110, is reasonable cause.

(8) The worker refused a suitable training site after the vocational counselor and worker have agreed in writing upon a return-to-work goal.

(9) The worker failed after written warning to participate in the development or implementation of a return-to-work plan. No written warning is required if the worker fails to attend two consecutive training days and fails, without reasonable cause, to notify the vocational counselor or the insurer by the close of next business day.

(10) The worker's lack of suitable employment cannot be resolved by providing vocational assistance. This includes circumstances in which the worker cannot benefit from, or participate in, vocational assistance because of medical conditions unrelated to the injury.

(11) The worker misrepresented information relevant to providing vocational assistance.

(12) The worker refused after written warning to return property provided by the insurer or reimburse the insurer as required. No vocational assistance will be provided under subsequent openings of the claim until the worker returns the property or reimburses the funds.

(13) The worker misused funds provided for the purchase of property or services. No vocational assistance will be provided under subsequent openings of the claim until the worker reimburses the insurer for the misused funds.

(14) After written warning the worker continues to harass any participant to the vocational process. This section does not apply if such behavior is the result of a documented medical or mental condition.

(15) The worker entered into a claim disposition agreement and disposed of vocational rights. The parties may agree in writing to suspend vocational services pending approval by the Workers' Compensation Board. The insurer must end eligibility when the Worker's Compensation Board approves the claims disposition agreement that disposes of vocational assistance rights. No notice regarding the end of eligibility is required.

(16) The worker received maximum direct employment services and is not entitled to other categories of vocational assistance.

Stat. Auth.: ORS 656.340, ORS 656.726(4)
Stat. Impltd.: ORS 656.340
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0175 Redetermining Eligibility for Vocational Assistance

If a worker was previously determined ineligible or the worker's eligibility ended, the insurer must redetermine eligibility within 35 days of notification of a change of these circumstances:

(1) The worker, for reasonable cause, was unavailable for vocational assistance and is now available.

(2) The worker's lack of suitable employment could not be resolved by providing vocational assistance. The insurer may require the worker to provide evidence that circumstances have changed.

(3) The worker declined vocational assistance to accept modified or new employment that resulted from an employer-at-injury-activated use of preferred worker benefits under OAR 436-110. If the job was not suitable, the worker must request redetermination within 30 days of termination of the employment for which preferred worker benefits were provided.

(4) The worker was not available for vocational assistance in Oregon or within commuting distance of Oregon. The worker must request redetermination within six months of receiving the insurer's notice that he or she was not eligible for this reason.

(5) The worker, who was not authorized to work in the United States, is now authorized to work in the United States. Within six months of the date of the worker's receipt of the insurer's notice of ineligibility or end of eligibility, the worker must:

(a) Request redetermination; and

(b) Submit evidence to the insurer that the worker has applied for authorization to work in the United States and is awaiting a decision by the U.S. Citizenship and Immigration Services (USCIS). The worker must provide the insurer with a copy of any decision by the USCIS within 30 days of receipt. The insurer must redetermine eligibility upon receipt of documentation of the worker's authorization to work in the United States.

(6) The worker, who returned to work prior to becoming medically stationary, informs the insurer that he or she is likely eligible for vocational assistance and requests a determination within 60 days of the mailing date of the Notice of Closure.

(7) Prior to claim closure, a worker's limitations due to the injury became more restrictive.

(8) Prior to claim closure, the insurer accepts a new condition that was not considered in the original determination of the worker's eligibility.

(9) The worker's average weekly wage is redetermined and increased.

Stat. Auth.: ORS 656.340, ORS 656.726(4)
Stat. Impltd.: ORS 656.340
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0185 Choosing a Vocational Assistance Provider

(1) Once the worker is found eligible, the insurer and worker must agree on a vocational assistance provider. Within 20 days of an eligibility finding, the insurer must notify the worker of the selection of vocational assistance provider. If they are unable to agree on a vocational assistance provider, the insurer or self-insured employer must notify the director and the director will select a provider.

(2) If the worker or insurer requests a change in vocational assistance provider, the insurer and worker must agree on a vocational assistance provider. If they are unable to agree, the insurer must refer the dispute to the director.

Stat. Auth.: ORS 656.340, ORS 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended and renumbered 12-1-2009 from OAR 436-120-0320 as WCD Admin. Order 09-061, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0320 Determining Eligibility for Vocational Assistance and Selection of Vocational Assistance Provider

Stat. Auth.: ORS 656.726(4), 656.340(9)
Stats. Implemented: ORS 656.206, (Oregon Laws, chapter 461), 656.340
Hist.: Amended and renumbered 12-1-2009 to 436-120-0115, 0125, 0135, 0145, 0155, & 0185 as WCD Admin. Order 09-061, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0340 Determining Substantial Handicap

(1) A certified vocational counselor must perform a substantial handicap evaluation as part of the eligibility determination when applicable.

(2) To complete the substantial handicap evaluation the vocational counselor must submit a report documenting the following information:

(a) Relevant work history for at least the preceding five years;

(b) Level of education, proficiency in spoken and written English or other languages, where relevant, and achievement or aptitude test data if it exists;

(c) Adjusted weekly wage as determined under OAR 436-120-0007 and suitable wage as defined by OAR 436-120-0005;

(d) Permanent limitations due to the injury;

(e) An analysis of the worker's transferable skills, if any;

(f) A list of physically suitable jobs for which the worker has the knowledge, skills and abilities, that pay a suitable wage, and for which a reasonable labor market is documented to exist as described in subsection (g) below;

(g) An analysis of the worker's labor market using standard labor market reference materials, including but not limited to information provided by the Employment Department's Oregon Labor Market Information System (OLMIS) and Oregon Wage Information (OWI). When using OWI data, the presumed standard will be the 10th percentile unless there is sufficient evidence that a higher or lower wage is more appropriate; and

(h) Consideration of the vocational impact of any limitations that existed prior to the injury.

(3) When determining the worker's eligibility for vocational assistance, the insurer may include any knowledge, skills, and abilities the worker gained after the date of injury or aggravation that resulted from training provided by the employer; however, the insurer may not include any knowledge, skills, or abilities the worker gained at his or her own expense after the date of injury or aggravation.

Stat. Auth.: ORS 656.726(4)
Stat. Impltd.: ORS 656.340(5) and (6)
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0400 Selection of Category of Vocational Assistance

(1) The insurer must select one of the following categories of vocational assistance before referring a worker to a vocational assistance provider:

(a) **Direct employment services**, if the worker has the necessary transferable skills to obtain suitable new employment.

(b) **Training**, if the worker needs training in order to return to employment which pays a wage significantly closer to 100 percent of the adjusted weekly wage. "Significantly closer" may vary depending on several factors, including, but not limited to, the worker's wage at injury, adaptability, skills, geographic location, limitations and the potential for the worker's income to increase with time as the result of training.

(2) The insurer must notify the worker of the category selection and the reason for the selection.

(3) The insurer must reconsider the category of vocational assistance within 30 days of the insurer's knowledge of a change in circumstances including, but not limited to:

(a) A change in the worker's permanent limitations;

(b) A change in the labor market; or

(c) The category of vocational assistance proves to be inappropriate.

(4) The insurer must notify the worker immediately if the reconsideration in section (3) results in a change in the vocational assistance category.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340(7)
Hist.: Amended 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0410 Vocational Evaluation

A certified vocational counselor must complete the vocational evaluation. Vocational evaluation may include one or more of the following:

(1) **Vocational testing** must be administered by an individual certified to administer the test.

(2) A **work evaluation** must be performed by a Certified Vocational Evaluation Specialist (CVE), certified by the Commission on Certification of Work Adjustment and Vocational Evaluation Specialists.

(3) **On-the-job evaluations** must evaluate a worker's work traits, aptitudes, limitations, potentials and habits in an actual job environment.

(a) First, the vocational counselor must perform a job analysis to determine if the job is within the worker's capacities. The insurer must submit the job analysis to the attending physician if there is any question about the appropriateness of the job.

(b) The evaluation should normally be no less than five hours daily for four consecutive days and should normally last no longer than 30 days.

(c) The evaluation does not establish any employer-employee relationship.

(d) A written report must evaluate the worker's performance in the areas originally identified for assessment.

(4) **Situational assessment** is a procedure that evaluates a worker's aptitude or work behavior in a particular learning or work setting. It may focus on a worker's overall vocational functioning or answer specific questions about certain types of work behaviors.

(a) The situational assessment requires these steps: planning and scheduling observations; observing, describing and recording work behaviors; organizing, analyzing and interpreting data; and synthesizing data including behavioral data from other pertinent sources.

(b) The assessment should normally be no less than five hours daily for four consecutive days and should normally last no longer than 30 days.

(5) **Work adjustment** is work-related activities that assist workers in understanding the meaning, value, and demands of work. It may include the assistance of a job coach.

(6) **Job analysis** is a detailed description of the physical and other demands of a job based on direct observation of the job.

(7) **Labor market search** is obtained from direct contact with employers, other actual labor market information, or from other surveys completed within 90 days of the report date.

(a) A labor market search is needed when standard labor market reference materials do not have adequate information upon which to base a decision, or there are questions about a worker's specific limitations, training and skills, that must be addressed with employers to determine if a reasonable labor market exists.

(b) The person giving the information must have hiring responsibility or direct knowledge of the job's requirements; and the job must exist at the firm contacted.

(c) The labor market search report must include, but is not limited to, the date of contact; firm name, address and telephone number; name and title of person contacted; the qualifications of persons recently hired; physical requirements; wages paid; condition of hire (full-time, part-time, seasonal, temporary); date and number of last hire(s); and available and anticipated openings.

(d) Specific openings found in the course of a labor market search are not, in themselves, proof a reasonable labor market exists.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340(7)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-061, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0430 Direct Employment

(1) If the insurer determines the worker is entitled to direct employment services, the insurer must provide an eligible worker with at least four months of direct employment services.

(2) Direct employment services must be provided by a certified vocational counselor.

(3) Direct employment services must begin on the date the insurer approves a direct employment plan, or on the completion date of an authorized training plan.

(4) Direct employment services may include, but are not limited to:

(a) Employment counseling.

(b) Job search skills instruction, which teaches workers how to write resumes, research the job market, locate suitable new employment, complete employment applications, interview for employment, and develop other skills related to obtaining suitable new employment.

(c) Job development with related return-to-work activities, which helps the worker contact appropriate prospective employers.

(d) Job analysis.

(5) The insurer must provide return-to-work follow-up for at least 60 days after the worker becomes employed to ensure the work is suitable and to provide any necessary assistance that enables the worker to continue the employment.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340(7)
Hist.: Amended 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0443 Training

(1) Training services include but are not limited to plan development, training, monthly monitoring of training progress, and job placement services.

(2) The training plan must be developed and monitored by a certified vocational counselor.

(3) The selection of plan objectives and the kind of training must attempt to minimize the length and cost of training necessary to prepare the worker for suitable employment.

(4) If there are any changes made to the original training plan, an addendum to Form 1081 – Return to Work Plan must be completed, signed by all parties, and submitted to the director.

(5) Basic education may be offered, with or without other training components, to raise the worker's education to a level to enable the worker to obtain suitable employment.

(6) On-the-job training prepares the worker for permanent, suitable employment with the training employer and for employment in the labor market at large. On-the-job training must be considered first in developing a training plan.

(7) Occupational skills training is offered through a community college, based on a predetermined curriculum, at the training employer's location.

(8) Formal training may be offered through a vocational school licensed by an appropriate licensing body, community

college, or other post-secondary educational facility that is part of a state system of higher education.

(9) Rehabilitation facilities training provides evaluation, training, and employment for severely disabled individuals.

(10) Notwithstanding OAR 436-120-0145(2), the director may order the insurer, or the insurer may elect, to provide training outside Oregon if such training would be more timely, appropriate, or cost effective than other alternatives.

(11) Training status continues during the following breaks:

(a) A regularly scheduled break of not more than six weeks between fixed school terms;

(b) A break of not more than two weeks between the end of one kind of training and the start of another for which the starting date is flexible; or

(c) A period of illness or recuperation that does not prevent completion of the training by the planned date.

(12) A worker actively engaged in training must receive temporary disability compensation under ORS 656.268 and ORS 656.340.

(13) Temporary disability compensation is limited to 16 months unless extended to 21 months by the insurer or ordered by the director when the injured worker provides good cause. Good cause may include but is not limited to the reasons given under section (14) of this rule. In no event will temporary disability compensation during training be paid for more than 21 months.

(14) Training costs may be paid for periods longer than 21 months. Reasons for extending training may include but are not limited to:

(a) Reasons beyond the worker's control.

(b) An "exceptional disability," defined as a disability equal to or greater than the complete loss, or loss of use, of both legs. Exceptional disability also includes brain injury that results in impairment equal or greater than Class III as defined in OAR 436-035.

(c) An "exceptional loss of earning capacity" exists when no suitable training plan of 16 months or less is likely to eliminate the worker's substantial handicap to employment. The extension must allow the worker to obtain a wage as close as possible to the worker's adjusted weekly wage and at least 10 percent greater than could be expected with a shorter training program.

(15) An eligible worker is entitled to four months of job placement assistance after completion of training.

(16) When the worker returns to work following training, the insurer must monitor the worker's progress for at least 60 days to assure the suitability of the employment before ending eligibility.

(17) If the worker chooses a training plan period of longer than he or she is entitled to receive under these rules, the worker may supplement training provided by the insurer by completing "self-sponsored" training or studies. For the purpose of this rule, "self-sponsored" means the worker is obligated to pay for the training.

(a) The first day of training provided by the insurer will be considered the "training start date" and the last day of training provided by the insurer will be the "training end date."

(b) All self-sponsored training must be completed before the training start date unless the parties otherwise agree.

(c) During self-sponsored training, the insurer may provide optional services under OAR 436-120-0455, including but not limited to payment of expenses for tuition, fees, books, and supplies.

(d) The return-to-work plan support document must describe how the worker-sponsored training and the training provided by the insurer will combine to prepare the worker for suitable employment.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impltd.: ORS 656.340
Hist: Amended 11/12/13 as Admin. Order 13-062, eff. 1/1/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0445 Training Requirements

(1) Basic education is limited to six months unless extended by the insurer.

(2) On-the-job training

(a) Training time is limited to 12 months unless extended by the insurer.

(b) The insurer must reimburse the training employer for a portion of the worker's wages.

(c) The on-the-job training contract between the training employer, the insurer, and the worker must include, but is not limited to:

(A) The worker's name;

(B) The employer's legal business name;

(C) The employer's current workers' compensation insurance policy number;

(D) The name of the individual providing the training;

(E) The training plan start and end dates;

(F) The job title and duties;

(G) The skills to be taught;

(H) The base wage and the terms of wage reimbursement;

(I) An agreement that the employer will pay all taxes normally paid on the entire wage and will maintain workers' compensation insurance for the trainee; and

(J) An acknowledgement that the training may not prepare the worker for jobs elsewhere, if the training prepares a worker for a job unique to the training site.

(d) The insurer must pay temporary disability compensation as provided in ORS 656.268.

(e) Absent a need to accommodate the worker's documented medical condition or class schedule, the worker's schedule must be the same as for a regular full-time employee.

(3) Occupational skills training

(a) Training is limited to 12 months unless extended by the insurer.

(b) The training is primarily for the worker's benefit. The worker does not receive wages.

(c) Training does not establish any employer-employee relationship with the training employer. The training employer makes no guarantee of employing the worker when the training is completed.

(d) The training employer has a sufficient number of employees to accomplish its regular work and the training of the worker, and the worker does not displace an employee.

(e) Absent a need to accommodate the worker's documented medical condition or class schedule, the worker's schedule must be the same as for a regular full-time employee.

(4) Formal training

(a) Training time is limited to 16 months unless extended by the insurer.

(b) Course load must be consistent with the worker's abilities, limitations, and length of time since the worker last attended school.

(c) Courses must relate to the vocational goal.

(5) If the worker begins or completes training between the date of injury and the date of the eligibility determination, and then the insurer finds the worker eligible for vocational assistance and finds the worker's training suitable, the insurer must reimburse the worker for costs required by that training and verified by the insurer or the director, including temporary disability as required under ORS 656.268 and ORS 656.340.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impltd.: ORS 656.340
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0447 Ending a Return to Work Plan

Amended and renumbered to 436-120-0448, 0449, and 0451

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended and renumbered to OAR 436-120-0448, 0449, and 0451, 10-3-2012 as WCD Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0448 Reevaluating a Training Plan

(1) A training plan must be re-evaluated when:

(a) A change occurs in the worker's limitations that may render the training inappropriate.

(b) In an academic program:

(A) The worker fails to maintain at least a 2.00 grade point average for two grading periods, or

(B) The worker fails to complete the minimum credit hours required under the training plan.

(2) In an academic program, the vocational counselor must notify the insurer, and the insurer must give the worker a written warning of the possible end of training, at the first indication that the worker may:

(a) Fail to maintain a 2.00 grade point average for two consecutive grading periods, or

(b) Fail to complete the minimum credit hours in the training plan curriculum.

(3) In a non-academic program, the vocational counselor must notify the insurer, and the insurer must give the worker a written warning of the possible end of training, at the first indication that the worker's performance in training is unsatisfactory and may not result in employment in that field.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impltd.: ORS 656.340
Hist: Amended and renumbered from OAR 436-120-0447, 10-3-2012 as WCD Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0449 Ending and Reevaluating a Training Plan

(1) Training ends and must be re-evaluated when:

(a) In an academic program:

(A) The worker fails, after written warning, to maintain at least a 2.00 grade point average for two consecutive grading periods, or

(B) The worker fails, after written warning, to complete the minimum credit hours in the training plan curriculum for two consecutive grading periods.

(b) In a non-academic program, the worker's performance in training is unsatisfactory and further training is not likely to result in employment in that field. The insurer must give the worker a written warning prior to ending the worker's training under this rule.

(2) A training plan re-evaluation may include a conference with the division, under OAR 436-120-0500(2).

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impltd.: ORS 656.340
Hist: Amended and renumbered from OAR 436-120-0447, 10-3-2012 as WCD Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0451 Ending a Training Plan

Training ends when:

(1) The worker has successfully completed training;

(2) The worker's eligibility has ended under OAR 436-120-0165; or

(3) The worker is not enrolled and actively engaged in the training; however, none of the reasons for ending training described in OAR 436-120-0443(11) will cause the worker's training status to end.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impltd.: ORS 656.340
Hist: Amended and renumbered from OAR 436-120-0447, 10-3-2012 as WCD Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0455 Optional Services

(1) Optional services are services provided to an ineligible worker or services provided to an eligible worker in excess of those described in these rules. Such services are at the discretion of an insurer.

(2) The insurer must not use optional services to circumvent the intent of these rules.

Stat. Auth.: ORS 656.283, 656.340, 656.704, 656.726
Stats. Implemented: ORS 656
Hist.: Amended 11/1/07 as WCD Admin. Order 07-067, eff. 12/1/07
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0500 Return-to-Work Plans: Development and Implementation

(1) A return-to-work plan should be a collaborative effort between the vocational counselor and the injured worker, and should include all the rights and responsibilities of the worker, the insurer, and the vocational counselor. Prior to submitting the plan to the insurer, the vocational counselor must review the plan and plan support with the worker. Certain information may be excluded, as allowed by OAR 436-010. The injured worker must be given the opportunity to review the plan with the worker's representative prior to signing it. The vocational assistance provider must confirm the worker's understanding of and agreement with the plan by obtaining the worker's signature. The counselor must submit copies signed by the vocational counselor and the worker to all parties. If the insurer lacks sufficient information to make a decision, the insurer must advise the parties what information is needed and when it expects to make a decision.

(2) If the insurer does not approve a return-to-work plan within 90 days of determining the worker is entitled to a training plan, or within 45 days of determining the worker is entitled to a direct employment plan, the insurer must contact the division within five days to schedule a conference. The purpose of the conference will be to identify and remove all obstacles to return-to-work plan completion and approval. The insurer, the worker, the plan developer, and any other parties involved in the return-to-work process must attend the conference. The conference may be postponed for a period of time agreeable to the parties. The insurer or the worker may request a conference with the division if other delays in the vocational rehabilitation process occur.

(3) If, during development of a return-to-work plan, an employer offers the worker a job, the insurer must perform a job analysis, obtain approval from the attending physician, verify the suitability of the wage, and confirm the offer is for a bona fide, suitable job as defined in OAR 436-120-0005. If the job is suitable, the insurer must help the worker return to work with the employer. The insurer must provide return-to-work follow-up during the first 60 days after the worker returns to work. If return to work with the employer is unfeasible or, during the 60-day follow-up the job proves unsuitable, the insurer must immediately resume development of the return-to-work plan.

(4) If the vocational goal or category of assistance is later changed, the insurer must amend the plan. All amendments to the plan must be initialed by the insurer, vocational assistance provider, and the worker.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340(9)
Hist.: Amended 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0510 Return-to-Work Plan Support

(1) The worker and vocational counselor must work together to develop a return-to-work plan that includes consideration of the following:

(a) The worker's transferable skills;

(b) The worker's physical and mental capacities and limitations;

(c) The worker's vocational interests;

(d) The worker's educational background and academic skill level;

(e) The worker's pre-injury wage; and

(f) The i worker's place of residence and that labor market.

(2) Return-to-work plan support must contain, but is not limited to, the following:

(a) Specific vocational goal(s) and projected return-to-work wage(s).

(b) A description of the worker's current medical condition, relating the worker's permanent limitations to the vocational goals.

(c) A description of the worker's education and work history, including job durations, wages, Standard Occupational Classification (SOC) codes or other standardized job titles and codes, and specific job duties. The SOC codes can be found on the Oregon Employment Department OLMIS website.

(d) If a direct employment plan, a description of the worker's transferable skills that relate to the vocational goals and a discussion of why training will not bring the worker a wage significantly closer to 100 percent of the adjusted weekly wage at the time of injury.

(e) If a training plan, a discussion of why direct employment services will not return the worker to suitable employment.

(f) A summary of the results of any evaluations or testing. If the results do not support the goals, the vocational assistance provider must explain why the goals are appropriate.

(g) A summary of current labor market information that shows the labor market supports the vocational goals and documents that the worker has been informed of the condition of the labor market.

(h) A labor market search as prescribed in 436-120-0410(7), if needed.

(i) If the labor market information does not support the goals, the vocational assistance provider must explain why the goals are appropriate. The worker and worker's representative, if any, must acknowledge in writing an awareness of the poor labor market conditions and a willingness to proceed with the plan in spite of these conditions. In the case of a training plan, this acknowledgment must include an understanding the insurer will provide no additional training should the worker be unable to find suitable employment because of the labor market.

(j) A job analysis prepared by the vocational assistance provider, signed by the worker and by the attending physician or a qualified facility designated by the attending physician, and based on a visit to a worksite comparable to what the worker could expect after completing training. If the attending physician is unable or unwilling to address the job analysis and does not designate a facility as described above, the insurer may submit the job analysis to a qualified facility of its choice.

The insurer must submit the resulting information to the attending physician for concurrence. If the attending physician has not responded within 30 days of the date of request for concurrence, the plan may proceed.

(k) A signed on-the-job training contract, if applicable.

(l) A description of the curriculum, which must be term by term if the curriculum is for formal training.

(m) If material pertinent to a return-to-work plan is contained in a previous eligibility the insurer may attach a copy of the evaluation to the plan.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impltd.: ORS 656.340
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0520 Return-to-Work Plan: Responsibilities of the Eligible Worker and the Vocational Assistance Provider

(1) The worker must participate and maintain contact with the vocational counselor throughout plan development and as required in the plan, and must inform the vocational counselor of anything which might affect the worker's participation in or successful completion of the plan. If the worker stops attending training for any reason, the worker must notify the vocational counselor by the close of the next working day.

(2) Vocational counselors are responsible for the following:

(a) During plan development, the vocational counselor must provide resource materials about jobs, training programs (if appropriate), labor markets and other pertinent information to help the worker select a vocational goal; direct information gathering; and otherwise help the worker analyze and evaluate options.

(b) The vocational counselor must help the worker plan the curriculum and help the worker enroll. The vocational assistance provider must contact the worker, trainers and training facility counselors to the extent necessary to assure the worker's participation and progress.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended 11/1/07 as WCD Admin. Order 07-067, eff. 12/1/07
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0530 Return-to-Work Plan Review

The director may review return-to-work plans and supporting information. If the director finds a return-to-work plan or its supporting information does not conform to these rules:

(1) The director must notify the insurer and vocational assistance provider in writing of the preliminary finding of nonconformance. The notification must inform the insurer of changes or information required to bring the plan into conformance.

(2) The insurer must, within 30 days of notification, make appropriate changes, supply additional information requested by the division, or explain why no change(s) should be made.

(3) If the insurer does not respond timely or is unable to bring the plan into conformance, the director will return the plan to the parties with notification that the plan does not conform to OAR 436-120 and may order the insurer to develop a plan that conforms to the rules.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended 11/1/07 as WCD Admin. Order 07-067, eff. 12/1/07
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0700 Direct Worker Purchases

(1) The insurer must provide direct worker purchases as necessary for an eligible worker's participation in vocational assistance and to meet the requirements of a suitable job. A worker is no longer eligible for these purchases once eligibility ends unless the purchases are necessary to complete a plan. Direct worker purchases include partial purchase, lease, rental and payment.

(2) Direct worker purchases will not include purchases of real property; payment of fines or other penalties; or payment of additional driver's license costs, increased insurance costs or any other costs attributable to problems with the worker's driving record.

(3) In making its decision regarding a direct worker purchase, the insurer may choose the least expensive, adequate alternative. If the worker wants a direct worker purchase which is more expensive than that authorized by the insurer, the worker may select that alternative, and the worker shall pay the difference in cost.

(4) Within 14 days of its receipt of a request for a direct worker purchase, the insurer must approve the purchase or notify the worker of its denial.

(5) The insurer must pay for approved direct worker purchases in time to prevent delay in the provision of services.

(6) The worker may pay for mileage, child or senior care, or for purchases such as clothing, books and supplies or the worker may request an advance of any of these costs based on documentation of need.

(a) The insurer must reimburse costs within 28 days of receiving the written request from the worker and any required supporting documentation.

(b) The insurer must return denied requests for reimbursement to the worker within 28 days of the insurer's receipt with an explanation of the reason for nonpayment.

(7) The insurer must assign to the worker right and title to the nonexpendable direct worker purchases paid by the insurer as follows:

(a) The insurer must make such assignment no later than the 60th day of continuous employment unless the worker remains eligible and the suitability of the employment is in question.

(b) The insurer may repossess nonexpendable property if the worker no longer requires the property for training or employment.

(c) The insurer may require repayment of advancements or reimbursements if the worker misrepresented information material to the purchase decision or if the worker used the funds for something other than the approved purchase.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340

Hist.: Amended 11/1/07 as WCD Admin. Order 07-067, eff. 12/1/07
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0710 Direct Worker Purchases: Kinds

The insurer must provide the direct worker purchases described in sections (1) through (12) of this rule without regard to the worker's pre- or post-injury income. The insurer may not require the worker to submit a financial statement in order to qualify for direct worker purchases listed in sections (1) through (12). In determining the necessity of direct worker purchases described in sections (13) through (18), the insurer must consider, among all factors, the worker's pre-injury net income as compared with the worker's post-injury net income. Permanent partial disability award payments will not be considered as income. For the insurer to find the purchase necessary, the worker's pre-injury net income, as adjusted by the cost-of-living matrix, must be greater than the worker's post-injury net income, unless the worker can establish financial hardship. The insurer may require the worker to provide information about expenditures or family income when the worker claims a financial hardship.

(1) Tuition, fees, books, and supplies for training or studies. Payment is limited to those items identified as mandatory by the instructional facility, trainer, or employer. The insurer must pay the cost in full, and will not require the worker to apply for grants to pay for tuition, books or other expenses associated with training.

(2) Wage reimbursement for on-the-job training. The amount must be stipulated in a contract between the training employer and the insurer.

(3) Travel expenses for transportation, meals, and lodging required for participation in vocational assistance. For the purposes of this section, "participation in vocational assistance" includes, but is not limited to job search, required meetings with the vocational assistance provider, and meetings with employers or at training sites as required by the plan or plan development. The conditions and rates for payment of travel expenses are as follows:

(a) Transportation. Costs will be paid at public transportation rates when public transportation is available; otherwise, mileage will be paid at the rate published in Bulletin 112. Costs incidental to mileage, such as parking fees, also will be paid. For workers receiving temporary total disability or equivalent income, private car mileage will be paid only for mileage in excess of the miles the worker traveled to and from work at the time of injury. Mileage payment in conjunction with moving expenses will be allowed only for one vehicle and for a single one-way trip. To receive reimbursement for private car mileage, the worker must provide the insurer with a copy of the driver's valid driver's license and proof of insurance coverage.

(b) Meals and lodging, overnight travel. For overnight travel, meal and lodging expense will be reimbursed at the rate published in Bulletin 112.

(c) Special travel costs. Payment will be made in excess of the amounts specified in this section when special transportation or lodging is necessary because of the physical needs of the worker, or when the insurer finds prevailing costs in the travel area are substantially higher than average.

(4) Tools and equipment for training or employment. Payment is limited to items identified as mandatory for the training or initial employment, such as starter sets. Purchases will not include what the trainer or employer ordinarily would provide to all employees or trainees in the training or employment, or what the worker possesses.

(5) Moving expenses. Payment is limited to workers with employment or training outside reasonable commuting distance. In determining the necessity of paying moving expenses, the insurer may consider the availability of employment or training which does not require moving, or which requires less than the proposed moving distance. Payment is limited to moving household goods weighing not more than 10,000 pounds. If necessary, payment includes reasonable costs of meals and lodging for the worker's family and mileage pursuant to subsection (3)(a) of this rule.

(6) Second residence allowance. The purpose of the second residence is to enable the worker to participate in training outside reasonable commuting distance. The allowance must equal the rental expense reasonably necessary, plus not more than $200 a month toward all other expenses of the second residence, excluding refundable deposits. In order to qualify for second residence allowance, the worker must maintain a permanent residence.

(7) Primary residence allowance. This allowance is applicable when the worker must change residence for training or employment. Payment includes the first month's rent and the last month's rent only if required prior to moving in.

(8) Medical examinations and psychological examinations for conditions not related to the compensable injury when necessary for determining the worker's ability to participate in vocational assistance.

(9) Physical or work capacities evaluations.

(10) Living expense allowance during vocational evaluation. Payment is limited to workers involved in a vocational evaluation at least five hours daily for four or more consecutive days, and not receiving temporary disability payments. The worker will not be barred from receiving a living expense allowance if the worker is unable to participate five hours daily because of limitations caused by the injury. Payment must be based on the worker's temporary total disability rate if the worker's claim were reopened.

(11) Work adjustment, on-the-job evaluation, or situational assessment cost(s).

(12) Membership fees and occupational certifications, licenses, and related testing costs. Payment under this category is limited to $500.

(13) Clothing required for participation in vocational assistance or for employment. Allowable purchases do not include items the trainer or employer would provide or the worker possesses.

(14) Child or disabled adult care services. These services are payable when required to enable the worker to participate in vocational assistance at rates prescribed by the State of Oregon's Department of Human Services. For workers receiving temporary total disability compensation or equivalent income, these costs will be paid only when in excess of what the worker paid for such services at the time of injury, adjusted using the cost-of-living matrix.

(15) Dental work, eyeglasses, hearing aids, and prosthetic devices. These are not related to the compensable injury and enable the worker to obtain suitable employment or participate in training.

(16) Dues and fees of a labor union. Payment will be limited to initiation fees, or back dues and one month's current dues.

(17) Vehicle rental or lease. There is no reasonable alternative enabling the worker to participate in vocational assistance or accept an available job. The worker must provide the insurer with proof of a valid driver's license and insurance coverage. Payment under this category is limited to $1,000.

(18) Any other direct worker purchase the insurer considers necessary for the worker's participation as described in the introductory paragraph of this rule. Payment under this category is limited to $1,000.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impltd.: ORS 656.340
Hist.: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0720 Fee Schedule and Conditions for Payment of Vocational Assistance Costs

(1) The director has established the following fee schedule for professional costs and direct worker purchases. The schedule sets maximum spending limits per claim opening for each category; however, the insurer may spend more than the maximum limit if the insurer determines the individual case so warrants. Spending limits are to be adjusted annually, effective July 1. The annual adjustment is based on the conversion factor described in OAR 436-120-0005 and published with the cost-of-living matrix.

(2) For workers found to have an exceptional disability or exceptional loss of earning capacity as defined in OAR 436-120-0443 the fee schedule spending limits for the Training category and DE/Training Combined category listed below must be increased by 30%.

(3) Amounts include professional costs, travel/wait, and other travel expenses:

Categories of Vocational Assistance	Professional Spending Limits	Direct Worker Purchases Spending Limits
Eligibility determination without substantial handicap analysis	54.7%	Not applicable (NA)
Substantial handicap analysis	109.4%	NA
Direct Employment	736.1%	368.1%
Training	1840.4%	2429.3%
DE/Training Combined	2044.8%	NA
Dispute Resolution	61.3%	NA

NOTE: *Each limit is shown as a percentage of Oregon's state average weekly wage (SAWW), determined under ORS 656.211. Dollar amounts are published in Bulletin 124 and are adjusted annually, effective July 1, based on changes in the SAWW.

(4) Wage reimbursement for on-the-job training contracts are not covered by the fee schedule.

(5) Services and direct worker purchases provided after eligibility ends to complete a plan or employment is subject to the maximum amounts in effect at the time of closure.

(6) The insurer must pay, within 60 days of receipt, the vocational assistance provider's billing for services provided under the insurer-vocational assistance provider agreement. The insurer must not deny payment on the grounds the worker was not eligible for the assistance if the vocational assistance provider performed the services in good faith without knowledge of the ineligibility.

(7) An insurer entitled to claims cost reimbursement under OAR 436-110 for services provided under OAR 436-120 is subject to the following limitations:

(a) Optional services are not reimbursable.

(b) The insurer must obtain the director's approval in advance for any waiver of the provisions of OAR 436-120.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340, 656.258
Hist.: Amended 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0755 Reimbursement of Vocational Assistance Costs from the Workers' Benefit Fund

(1) The director will reimburse the insurer or self-insured employer for costs associated with providing vocational benefits when:

(a) The director issues an order overturning the insurer's or self-insured employer's denial of vocational benefits; and

(b) The insurer's or self-insured employer's denial is later upheld by a final order.

(2) To receive reimbursement from the Workers' Benefit Fund, the insurer or self-insured employer must provide the division with the following documentation, within one year from the date of the final order:

(a) Injured worker's name and Workers' Compensation Division's claim file number;

(b) Date and order number of the director's order appealed;

(c) Itemized listing with dates of service for all costs incurred after the date of the director's order that was reversed. All costs, in order to be reimbursed, must meet all conditions set forth in OAR 436-120, and reimbursement requests must:

(A) Use terms, "direct employment" or "training" to show the category of vocational assistance provided;

(B) List vocational provider costs by category of "professional services";

(C) List direct worker purchases by the categories in OAR 436-120-0710, to include purchase dates and costs;

(D) Show temporary total disability paid between the start and end dates of the return to work plan; and

(E) List any other costs incurred in providing vocational benefits as a result of the order that was appealed.

(d) Signed certified statement that the requested reimbursement amount was actually paid; and

(e) The insurer's or self-insured employer's name and address where reimbursement is to be sent.

(3) The director may require additional information to clarify and process a reimbursement request.

(4) No reimbursement is allowed for the insurer's administrative costs.

Stat. Auth.: 656.726(4)
Stats. Implemented: Oregon Laws 2005, chapter 588, sections 4 & 5; ORS 656.313, 656.605
Hist.: Filed 12/5/05 as WCD Admin. Order 05-080 eff. 01/01/06

436-120-0800 Registration of Vocational Assistance Providers

(1) A vocational assistance provider may not provide vocational assistance services unless they are first registered by the director under this rule.

(2) A vocational assistance provider must submit an application that includes:

a description of the specific vocational services to be provided and verification of staff certifications under these rules;

(3) The director may approve or deny registration based on the completed application and the department's registration and counselor certification records.

(a) The registration will specify the scope of authorized vocational services as determined by the vocational assistance provider's staff certifications.

(b) Vocational assistance providers whose registration is denied under this rule may appeal as described in OAR 436-120-0008.

(4) A registered vocational assistance provider must:

(a) Notify the division within 30 days of any changes in office address, telephone number, contact person or staff.

(b) Maintain the worker's vocational assistance files for four years after the end of vocational assistance with that vocational assistance provider, or in a pre-1986 case, for five years after the end of vocational assistance with that provider.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-061, eff.1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0810 Certification of Individuals

Individuals determining workers' eligibility and providing vocational assistance must be certified by the director and on the staff of a registered vocational assistance provider, insurer, or self-insured employer.

(1) An applicant for certification must submit an application, as prescribed by the director, demonstrating the qualifications for the specific classification of certification as described in OAR 436-120-0830.

(2) Department certification is not required to perform work evaluations, but the work evaluator must be certified by the professional organizations described in OAR 436-120-0410(2).

(3) The director may approve or disapprove an application for certification based on the individual's application.

(a) Certification will be granted for five years. A vocational counselor who is nationally certified as described in OAR 436-120-0830(1)(a) will be granted an initial certification period to coincide with their national certification.

(b) Certified individuals must notify the division within 30 days of any changes in address and telephone number.

(c) Individuals whose certification is denied under this rule may appeal as described in OAR 436-120-0008.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-061, eff.1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0820 Renewal of Certification

(1) A certified individual must renew their certification every five years by submitting the following documentation to the director no later than 30 days prior to the end of their certification period:

(a) Current certification by the Commission on Rehabilitation Counselor Certification (CRCC) or the Commission for Case Managers Certification (CCMC) or the Certification of Disability Management Specialists Commission (CDMSC) and six hours of training on the Oregon vocational assistance and reemployment assistance rules; or

(b) Verification of a minimum of 60 hours of continuing education units under this rule within the five years prior to renewal.

(A) At least eight hours must be for training in ethical practices in rehabilitation counseling.

(B) At least six hours of training must be on the Oregon vocational assistance and reemployment assistance rules. Individuals already certified on the effective date of these rules will have no less than one year to complete this requirement.

(2) The department will accept continuing education units for training approved by the CRCC, CCMC or the CDMSC; courses in or related to psychology, sociology, counseling, and vocational rehabilitation, if given by an accredited institution of higher learning; training presented by the department pertaining to OAR 436-120, 436-105, and 436-110; and any continuing education program certified by the department for vocational rehabilitation providers. Sixty minutes of continuing education will count as one unit, except as noted in section (3) of this rule.

(3) In the case of college course work, the department will grant credit only for grades of C or above and will multiply the number of credit hours by six to establish the number of continuing education units.

(4) Failure to meet the requirements of this section will cause an individual's certification to expire. Such an individual may reapply for certification upon completion of the required 60 hours of continuing education.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0830 Classification of Vocational Assistance Staff

Individuals providing vocational assistance will be classified as follows:

(1) Vocational Rehabilitation Counselor certification allows the individual to determine eligibility and provide vocational assistance services. Vocational Rehabilitation Counselor certification requires:

(a) Certification by the following national certifying organizations: Commission on Rehabilitation Counselor Certification (CRCC), the Commission for Case Managers Certification (CCMC), or the Certification of Disability Management Specialists Commission (CDMSC);

(b) A master's degree in vocational rehabilitation counseling and at least six months of direct experience;

(c) A master's degree in psychology, counseling, or a field related to vocational rehabilitation, and 12 months of direct experience; or

(d) A bachelor's or higher degree and 24 months of direct experience. Thirty-six months of direct experience may substitute for a bachelor's degree.

(2) Vocational Rehabilitation Intern certification allows an individual who does not meet the requirements for certification as a Vocational Rehabilitation Counselor the opportunity to gain direct experience. Vocational Rehabilitation Intern certification requires a master's degree in psychology, counseling, or a field related to vocational rehabilitation; or a bachelor's degree and at least six hours of training on the Oregon vocational assistance and reemployment assistance rules. Thirty-six months of direct experience may substitute for a bachelor's degree. The Vocational Rehabilitation Intern certification is subject to the following conditions:

(a) The intern must be supervised by a certified Vocational Rehabilitation Counselor who must co-sign and assume responsibility for all the intern's eligibility determinations, return-to-work plans, vocational and billing reports.

(b) When the intern has met the experience requirements, the intern may apply for certification as a Vocational Rehabilitation Counselor.

(3) Return-to-Work Specialist certification allows the person to provide job search skills instruction, job development, return-to-work follow-up, labor market search, and to determine eligibility for vocational assistance, except where such determination requires a judgment as to whether the worker has a substantial handicap to employment. This certification requires 24 months of direct experience. Full-time (or the equivalent) additional college coursework in psychology, counseling, education, a human services related field, or a field related to vocational rehabilitation may substitute for up to 18 months of direct experience, on a month-for-month basis. To conduct only labor market research /or job development does not require certification when conducted under the supervision of a certified vocational rehabilitation counselor.

(4) To meet the direct experience requirements for Vocational Rehabilitation Counselor, the individual must:

(a) Perform return-to-work plan development and implementation for the required number of months; or

(b) Perform three or more of the qualifying job functions listed in paragraphs (A) through (J) of this subsection for the required number of months, with at least six months of the experience in one or more of functions listed in paragraphs (A) through (D) of this subsection. The qualifying job functions are:

(A) Return-to-work plan development and implementation;

(B) Employment counseling;

(C) Job development;

(D) Early return-to-work assistance which must include working directly with workers and their employers;

(E) Vocational testing;

(F) Job search skills instruction;

(G) Job analysis;

(H) Transferable skills assessment or employability evaluations;

(I) Return-to-work plan review and approval; or

(J) Employee recruitment and selection for a wide variety of occupations.

(5) To meet the direct experience requirements for Vocational Rehabilitation Intern or Return-to-Work Specialist, the individual must:

(a) Perform return-to-work plan development and implementation for the required number of months; or

(b) Perform three or more of the qualifying job functions listed in paragraphs (4)(b)(A) through (J) of this rule for the required number of months.

(6) To receive credit for direct experience, the individual must:

(a) Perform one or more of the qualifying job functions listed in paragraphs (4)(b)(A) through (J) of this rule at least 50 percent of the work time for each month of direct experience credit. Qualifying job functions performed in a job that is less than full time will be prorated. For purposes of this rule, full time will be 40 hours a week. An individual will not receive credit for any function performed less than 160 hours.

(b) Provide any documentation required by the director, including work samples. The director may also require verification by the individual's past or present employers.

(7) All degrees must be from accredited institutions and documented by a copy of the transcript(s) with the application for certification.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0840 Professional Standards for Registered Vocational Assistance Providers and Certified Individuals

(1) Registered vocational assistance providers and certified individuals must:

(a) Determine eligibility and provide assistance in an objective manner not subject to any conditions other than those prescribed in these rules;

(b) Fully inform the worker of the categories and kinds of vocational assistance under OAR 436-120 and reemployment assistance under OAR 436-110;

(c) Document all case activities in legible file notes or reports;

(d) Provide only vocationally relevant information about workers in written and oral reports;

(e) Recommend workers only for suitable employment;

(f) Fully inform the worker of the purpose and results of all testing and evaluations and

(g) Comply with generally accepted standards of conduct in the vocational rehabilitation profession.

(2) Registered vocational assistance providers and certified individuals must not:

(a) Provide evaluations or assistance if there is a conflict of interest or prejudice concerning the worker;

(b) Enter into any relationship with the worker to promote personal gain, or the gain of a person or organization in which the vocational assistance provider or certified individual has an interest;

(c) Engage in, or tolerate, sexual harassment of a worker. "Sexual harassment" means deliberate or repeated comments, gestures or physical contact of a sexual nature;

(d) Violate any applicable state or federal civil rights law;

(e) Commit fraud, misrepresent, or make a serious error or omission, in connection with an application for registration or certification;

(f) Commit fraud, misrepresent, or make a serious error or omission in connection with a report or return-to-work plan, or the vocational assistance activities or responsibilities of a vocational assistance provider under OAR chapter 436;

(g) Engage in collusion to withhold information, or submit false or misleading information relevant to the determination of eligibility or provision of vocational assistance;

(h) Engage in collusion to violate these rules or other rules of the department, or any policies, guidelines or procedures issued by the director;

(i) Fail to comply with an order by the director to provide specific vocational assistance, except as provided in ORS 656.313; or

(j) Instruct any individual to make decisions or engage in behavior that is contrary to the requirements of these rules.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.313, 656.340
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-061, eff.1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0900 Audits, Penalties and Sanctions

(1) Insurers and employers at injury must fully participate in any department audit, periodic program review, investigation or review, and provide records and other information as requested.

(2) If the director finds the insurer or employer at injury failed to comply with OAR 436-120, the director may impose one or more of the following sanctions:

(a) Reprimand by the director.

(b) Recovery of reimbursements.

(c) Denial of reimbursement requests.

(d) An insurer or employer may be assessed a civil penalty under ORS 656.745 for any violation of statutes, rules, or orders of the director.

(3) In determining the amount of a civil penalty to be assessed the director may consider:

(a) The degree of harm inflicted on the worker;

(b) Whether there have been previous violations or warnings; and

(c) Other matters as justice may require.

(4) Under ORS 656.447, the director may suspend or revoke an insurer's authority to issue worker's compensation insurance policies upon determination that the insurer has failed to comply with these rules.

Stat. Auth.: ORS 656.340, 656.726(4)
Stats. Implemented: ORS 656.340, 656.447, 656.745(1) and (2)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-061, eff.1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0915 Sanctions of Registered Vocational Assistance Providers and Certified Individuals

(1) Vocational assistance providers and certified individuals must fully participate in any department audit, periodic program review, investigation or review, and provide records and other information as requested.

(2) If the director finds any registered vocational assistance provider or certified individual failed to comply with OAR 436-120, the director may impose one or more of the following sanctions:

(a) Reprimand by the director.

(b) Probation, in which the department systematically monitors the vocational assistance provider's or individual's compliance with OAR 436-120 for a specified length of time. Probation may include the requirement an individual receive supervision, or successfully complete specified training, personal counseling or drug or alcohol treatment.

(c) Suspension, which is the termination of registration or certification to determine eligibility and provide vocational assistance to Oregon injured workers for a specified period of time. The vocational assistance provider or individual may reapply for registration or certification at the end of the suspension period. If granted, the vocational assistance provider or individual will be placed on probation as described in subsection (2)(b) of this rule.

(d) Revocation, which is a permanent termination of registration or certification to determine eligibility and provide vocational assistance to Oregon injured workers.

(3) The director will investigate violations of OAR 436-120 and may impose a sanction under these rules. Before issuing a suspension or revocation, the director will send a notice of the proposed action and provide the opportunity for a show-cause hearing. The process is as follows:

(a) The director will send by certified mail a written notice of intended suspension or revocation and the grounds for such action. The notice must advise of the right to participate in a show-cause hearing.

(b) The vocational assistance provider or individual has 10 days from the date of receipt of the notification of proposed action in which to request a show-cause hearing.

(c) If the vocational assistance provider or individual does not request a show-cause hearing, the proposed suspension or revocation will become final.

(d) If the vocational assistance provider or individual requests a show-cause hearing, the director will send a notification of the date, time and place of the hearing.

(e) After the show-cause hearing, the director will issue a final order which may be appealed as described in OAR 436-120-0008(3).

(4) For the purposes of section (3) "show-cause hearing" means an informal meeting with the director in which the vocational assistance provider or certified individual will be provided an opportunity to be heard and present evidence regarding any proposed actions by the director to suspend or revoke a vocational assistance provider or certified individual's authority to provide vocational assistance services to injured workers.

(5) The director may bar a vocational assistance provider or individual who has received a suspension or revocation under this rule from sponsoring or teaching continuing education programs.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-061, eff.1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 140

CONSTRUCTION CARVE-OUT PROGRAMS

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436-140-0001 Authority For Rules

These rules are promulgated under the director's authority pursuant to ORS 656.726(4) and 656.174.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0002 Purpose

The purpose of these rules is to implement ORS 656.170 and 656.172, and to establish and provide procedures and requirements for the administration and enforcement of programs entered into under ORS 656.170 and 656.172.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0003 Applicability of Rules

(1) These rules shall be applicable on their effective date and thereafter to carry out the provisions of ORS 656.170 and 656.172.

(2) Notwithstanding sections 2 and 3, chapter 841, Oregon Laws 1999 (ORS 656.170 and 656.172), prior to January 1, 2002 the director may issue letters of eligibility to only two qualified unions for participation in an alternative dispute resolution system authorized under section 2 of the 1999 Act (656.170). The director may not issue letters of eligibility after January 1, 2002.

(3) These rules apply to parties to a collective bargaining agreement only insofar as **and** only to the extent that the agreement contains the provisions provided by ORS 656.170, has been approved by the director, and for which eligibility has been established under these rules.

(4) Except as otherwise provided by law, the provisions of ORS Chapter 656, OAR Chapter 436, and OAR Chapter 438 apply to programs entered into under these rules, unless the collective bargaining agreement expressly specifies otherwise.

(5) Applicable to this chapter, the director may, unless otherwise obligated by statute, waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0005 Definitions

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

(1) "Alternative dispute resolution system" means a process that exists outside the normal Workers' Compensation system to settle disputes arising from a workers' compensation claim.

(2) "Arbitration" means the hearing and determination of a case in controversy by an arbiter.

(3) "Collective bargaining representative" means a person who represents a union.

(4) "Construction carve-out program" means a program established pursuant to ORS 656.170 and 656.172 for either an alternative dispute resolution system or use of a list of medical service providers, or both, which the director has approved and for which eligibility has been established under these rules.

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

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

(7) "Employer" is limited to a private employer, or group of employers, engaged in construction; construction maintenance; or activities limited to rock, sand, gravel, cement and asphalt operations; heavy duty mechanics; surveying; or construction inspection.

(8) "Employee" is limited to an employee of an employer defined by section (7) of this rule.

(9) "Insurer" includes "insurer," "guaranty contract insurer," and "self-insured employer" as defined by ORS 656.005.

(10) "Letter of eligibility" means a letter issued by the director under ORS 656.172(4) indicating that eligibility to participate in a construction carve-out program has been established under ORS 656.170 and ORS 656.172.

(11) "Mediation" means the act or process of intervening between conflicting parties to promote reconciliation, settlement, or compromise.

(12) "Plan administrator" means the person responsible for administering the Construction Carve-Out Program.

(13) "Union" means a collective bargaining union that is recognized or certified as the exclusive bargaining representative of employees for an employer or group of employers.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0006 Administration of Rules

Any orders issued by the division in carrying out the director's authority under ORS Chapter 656 and these rules are considered orders of the director.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0008 Administrative Review

(1) If the director determines that a proposed construction carve-out program is not eligible, the director will issue a notice to the employer or collective bargaining representative.

(a) Under ORS 656.704(2), if the employer or collective bargaining representative disagrees with the notice, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the notice.

(b) OAR 436-001 applies to the hearing.

(2) If the director determines that the acts or omissions of a construction carve-out program justify suspension, the director may issue a notice of intent to suspend eligibility pursuant to OAR 436-140-0090 and schedule a hearing on the matter of suspension. The notice must be served upon the employer or collective bargaining representative as provided in OAR 436-140-0130.

(a) At a hearing on a notice of intent to suspend, the employer or collective bargaining representative must show cause why eligibility should not be suspended.

(A) If the director determines that the acts or omissions of the employer or collective bargaining representative justify suspension, the director may issue an order suspending eligibility. If the director determines that the acts or omissions of the employer or collective bargaining representative do not justify suspension, the director shall issue an order withdrawing the notice.

(B) The order must be served upon the employer or collective bargaining representative as provided in OAR 436-140-0130.

(C) If the employer or collective bargaining representative disagrees with the order, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(D) OAR 436-001 applies to the hearing.

(3) If the director determines that the acts or omissions of a construction carve-out program justify revocation, the director may issue a notice of intent to revoke eligibility pursuant to OAR 436-140-0090. The notice must be served upon the employer or collective bargaining representative as provided in OAR 436-140-0130.

(a) The revocation shall become effective within 10 days after service of notice, unless within such period of time the employer or collective bargaining representative correct(s) the grounds for revocation to the satisfaction of the director or files a written request for hearing with the director.

(A) If the employer or collective bargaining representative request(s) a hearing, the director will set a date and time, and give at least 10 days' notice of the hearing. At hearing, the employer or collective bargaining representative must show cause why eligibility should not be revoked.

(B) Within 30 days after the hearing, the director shall issue an order affirming or withdrawing the revocation. The director shall serve a copy of the order upon the employer or collective bargaining representative as provided in OAR 436-140-0130.

(C) If the employer or collective bargaining representative disagrees with the order, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(D) OAR 436-001 applies to the hearing.

(b) An emergency revocation issued pursuant to OAR 436-140-0090(5), is effective immediately. To contest the revocation, the employer or collective bargaining representative must file a request for hearing within 60 days of the mailing date of the order; the revocation shall remain in effect until the director orders otherwise. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174, 656.704, OL 2005 ch 26
Hist.: Amended 10/19/05 as WCD Admin. Order 05-069, eff. 1/2/06
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-140-0010 Qualifying

(1) An employer, group of employers or collective bargaining representative may not establish or continue to participate in a construction carve-out program under ORS 656.170 until the proposed program has been approved by the director and the director has issued a letter of eligibility. An application containing the information described in subsections (2) and (3) of this rule must be submitted to the director.

(2) The employer or group of employers must provide at least the following:

(a) Payroll records sorted by National Council on Compensation Insurance (NCCI) classification for one of the three years prior to the year in which the collective bargaining agreement takes effect.

(b) A proposed plan for the construction carve-out program, along with four copies, in which it is demonstrated how the proposed construction carve-out program will meet the requirements of ORS 656.170, 656.172, and these rules;

(c) A copy of the collective bargaining agreement;

(d) An estimate of the number of employees covered by the collective bargaining agreement;

(e) A copy of a valid license when that license is required of the employer or group of employers to conduct business in Oregon;

(f) A signed, sworn statement that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement;

(g) The name, address, and telephone number of the contact person of the employer or group of employers;

(h) A statement from the insurer or self-insured employer that the insurer or self-insured employer is willing to insure the risk under the terms of the collective bargaining agreement; and

(i) If applicable, a list of the names, addresses, and specialties of the medical service providers who will provide medical services under the construction carve-out program, together with appropriate evidence of any licensing, registration or certification requirements for that individual to practice. This list shall indicate which medical service providers will act as attending physicians.

(3) The collective bargaining representative must provide at least the following:

(a) A copy of the most recent LM-2 or LM-3 filing with the United States Department of Labor, and a signed, sworn statement that the document is a true and correct copy; and

(b) The name, address, and telephone number of the contact person for the collective bargaining representative.

(4) Within 45 days of receipt of the information required by subsections (2) and (3), the director will notify the applicants that the program is or is not approved. A letter of eligibility will be issued if the program is approved. If the program is not approved, a notice will be issued. The notice will include the reasons the program is not approved and a notice of appeal rights under OAR 436-140-0008(1). The notice will be served upon the employer and/or collective bargaining representative as provided in OAR 436-140-0130.

(5) Upon issuance of a letter of eligibility, those provisions of the collective bargaining agreement or other documents entered into under ORS 656.170(1) are considered valid and binding, subject to the terms of the agreement.

(6) One in-state location shall be established where the construction carve-out program is administered and records are maintained.

(7) No construction carve-out program shall be approved that diminishes the entitlement of an employee to compensation as provided by ORS Chapter 656.

(8) No more than two unions may qualify for participation in a construction carve-out program. In establishing qualification, the director will process all applications in the order in which they are received.

(9) The employer, or group of employers, and collective bargaining representative shall meet the reporting requirements under OAR 436-140-0070 in order to continue to participate in a construction carve-out program.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0020 Alternative Dispute Resolution

(1) A construction carve-out program may establish and operate an alternative dispute resolution system governing disputes between employees, employers, and their insurers. Any such system may include, but not be limited to:

(a) Limitations on the liability of the employer while determinations regarding the compensability of an injury are being made;

(b) A method for resolving disputes involving compensability of injuries and the amount of compensation due for a compensable injury, medical services, and legal services;

(c) A method for payment of compensation for injuries incurred under the collective bargaining agreement, when the worker is no longer subject to the agreement; or

(d) Arbitration and mediation procedures.

(2) If a construction carve-out program establishes an alternative dispute resolution

system, a dispute to which that system applies shall first be processed through that system before it is brought before another forum.

(3) The plan administrator shall provide a written summary of the alternative dispute resolution system process to all parties to a dispute, or upon request. The written summary shall include at least the following:

(a) The title, address, and telephone number of a contact person for the alternative dispute resolution system process;

(b) The types of disputes to which the alternative dispute resolution system will apply and the types of disputes, if any, to which the dispute resolution processes provided by ORS Chapter 656, OAR Chapter 436, and/or OAR Chapter 438 will apply;

(c) A description of the procedures and time frames at each level of the alternative dispute resolution system process; and

(d) A statement of the right of an aggrieved party to request review by the Workers' Compensation Board, and reference to the applicable Board rules, after completion of the alternative dispute resolution system process.

(4) Written notification must be provided to all parties, including the worker's attorney if the worker is represented, when the alternative dispute resolution system receives a dispute for resolution and when the dispute resolution system issues any decision in that dispute. The notice shall inform the parties of the status of the dispute, and of the next level of the dispute resolution process.

(5) The time frame for resolution of a dispute by the alternative dispute resolution system, from date of receipt of a dispute until agreement or completion of the highest level of the system, including issuance of a final decision, shall not exceed 180 days without approval of all parties.

(6) The director may, at any time and/or upon request, issue an order to further the dispute resolution system process.

(7) The alternative dispute resolution system shall develop a record sufficient for any party to appeal a decision by the alternative dispute resolution system.

(8) An aggrieved party to any decision, order or award of compensation issued under the alternative dispute resolution system may request review by the Workers' Compensation Board in accordance with Chapter 656 and OAR Chapter 438 after completion of the alternative dispute resolution system.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0030 Medical Services

(1) A construction carve-out program may establish a list of medical service providers that the parties agree is the exclusive source of all medical treatment provided under ORS chapter 656.

(2) A construction carve-out program shall establish a method for access to medical services for workers no longer subject to the agreement when those injuries were sustained under the collective bargaining agreement.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0040 Compensation

Benefit amounts that exceed the statutory rates under ORS Chapter 656 shall not be subject to reimbursement from the Workers' Benefit Fund.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0045 Multiple Claims; Expiration or Termination of Collective Bargaining Agreement; Responsibility

(1) Disputes involving multiple claims when one or more of the claims are not subject to the collective bargaining agreement shall be resolved pursuant to ORS 656.307, 656.308, and OAR Chapter 436.

(2) Upon expiration of the collective bargaining agreement without renewal, or after termination of any arrangement under ORS 656.170 and 656.172, the insurer is responsible for benefits and claims in accordance with the provisions of ORS Chapter 656 unless otherwise provided for under the agreement.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0050 Duties and Responsibilities of Employer

(1) An employer or group of employers that participates in a construction carve-out program shall comply with coverage requirements under ORS 656.017.

(2) The participating employer or group of employers shall report all claims made under the program to the insurer as with other claims.

(3) The participating employer or group of employers shall comply with the terms of the collective bargaining agreement and construction carve-out program.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0060 Insurer Duties and Responsibilities

(1) An insurer who contracts to provide coverage to an employer or group of employers under a construction carve-out program shall timely report claims made under the construction carve-out program to the director.

(2) The insurer shall provide benefits in accordance with the terms of the collective bargaining agreement and construction carve-out program.

(3) The insurer shall segregate all loss and payroll data for reporting and research purposes. Data shall be forwarded to the director upon request.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0070 Reporting Requirements

(1) In order to ensure the construction carve-out program continues to comply with the eligibility requirements of these rules, the employer, or group of employers, and collective bargaining representative shall:

(a) upon renegotiation of the collective bargaining agreement, provide the director with a copy no less than 30 days before the agreement takes effect, including an estimate of the number of employees covered by the agreement; and

(b) on an annual basis, provide the director the following:

(A) A copy of a valid license when that license is required of the employer or group of employers to conduct business in Oregon;

(B) A signed, sworn statement that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement;

(C) The name, address, and telephone number of the contact person of the employer or group of employers;

(D) A statement from the insurer or self-insured employer that the insurer or self-insured employer is willing to insure the risk under the terms of the collective bargaining agreement;

(E) A copy of the most recent LM-2 or LM-3 filing with the United States Department of Labor, and a signed, sworn statement that the document is a true and correct copy; and

(F) The name, address, and telephone number of the contact person for the collective bargaining representative.

(2) Upon request of the director, a construction carve-out program shall provide a listing by category of medical service providers, including provider names, specialty, Tax ID number, Oregon license number, business address and phone number. The listing shall include all health care providers participating in the construction carve-out program.

(3) Nothing in this rule limits the director's authority to require information as necessary to monitor compliance with these rules.

(4) The plan administrator and/or insurer may apply to the director for approval to modify forms or notices required by

rule or bulletin. No modified form or notice shall be used without the director's prior approval.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0090 Suspension or Revocation

(1) Prior eligibility of a construction carve-out program may be suspended or revoked if any of the following occur:

(a) the director finds a serious danger to the public health or safety;

(b) the construction carve-out program fails to provide services under the terms of the collective bargaining agreement;

(c) the employer, or group of employers, collective bargaining representative, and/or insurer fails to comply with ORS Chapter 656, OAR 436-140, or orders of the director; or

(d) the employer, or group of employers, collective bargaining representative, and/or insurer submits any false or misleading information pertaining to the eligibility.

(2) The director shall provide written notice of intent to suspend or revoke eligibility.

(a) The notice shall:

(A) describe generally the acts and the circumstances that would be grounds for suspension or revocation; and

(B) advise of the right to a hearing in the case of revocation; and the date, time and place of the hearing in the case of suspension.

(b) The notice shall be served as provided in OAR 436-140-0130.

(3) The hearing shall be conducted as provided in OAR 436-140-0008.

(4) Suspension or revocation shall have the effect of removing director approval and eligibility of the construction carve-out program. A revoked program will have to re-apply for director approval and a letter of eligibility to be effective.

(5) Notwithstanding any other provision of this rule, in any case where the director finds a serious danger to the public health or safety and sets forth specific reasons for such findings, the director may immediately revoke the eligibility of a construction carve-out program without opportunity for a hearing. The order must be served upon the employer and/or collective bargaining representative as provided in OAR 436-140-0130. Such order shall be final, unless the parties request a hearing. The process for review shall be as provided in OAR 436-140-0008.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0100 Monitoring/Auditing

(1) The director may conduct periodic audits of construction carve-out programs as necessary to ensure compliance with ORS 656.170, 656.172, and these rules.

(2) All records of a construction carve-out program shall be produced upon request of the director.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0120 Sanctions and Civil Penalties; Rule Violations

(1) Pursuant to ORS 656.745 any employer, group of employers, and/or insurer shall be subject to penalties if the director finds it in violation of OAR 436-140 or an order of the director. The penalty shall not be more than $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, shall be considered a separate violation.

(2) Any complaint alleging a violation of these rules shall be made in writing to the director. The complaint must:

(a) state the grounds for the alleged rule violation;

(b) include the specific instances of the alleged rule violation;

(c) state the complainant's request for correction and relief; and

(d) include sufficient documentation to support the complaint.

(3) If the director determines upon investigation that a rule violation has occurred, the director may issue penalties pursuant to ORS 656.745 and this rule.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0130 Service of Orders

(1) An order or notice of the director shall include a notice of the party's appeal rights and shall be served upon the party when the director does any of the following:

(a) notifies an applicant that a program is not approved pursuant to OAR 436-140- 0010(4);

(b) suspends or revokes eligibility of a construction carve-out program pursuant to OAR 436-140-0090; or

(c) assesses a civil penalty under the provisions of OAR 436-140-0120.

(2) The director shall serve the order by delivering a copy to the party in the manner provided by Oregon Rules of Civil Procedure 7D(3), or by sending a copy to the party by certified mail with return receipt requested.

Stat. Auth.: ORS 656.726(4), 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174
Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 150

WORKERS' BENEFIT FUND CLAIMS PROGRAM

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436-150-0001 Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.726(4) and section 6, chapter 974, Oregon Laws 2001.

Stat. Auth.: Section 6, chapter 974, Oregon Laws 2001, ORS 656.726(4)
Stats. Implemented: Section 6, chapter 974, Oregon Laws 2001
Hist.: Adopted 12/6/01 as WCD Admin. Order 01-063, eff. 1/1/02

436-150-0002 Purpose

The purpose of these rules is to establish guidelines for regulating, managing, and disbursing moneys in the Workers' Benefit Fund for the purpose of advancing funds to injured workers who have not received payment of compensation due from an insurer in default.

Stat. Auth.: Section 6, chapter 974, Oregon Laws 2001, ORS 656.726(4)
Stats. Implemented: Section 6, chapter 974, Oregon Laws 2001
Hist.: Adopted 12/6/01 as WCD Admin. Order 01-063, eff. 1/1/02

436-150-0003 Applicability of Rules

(1) These rules carry out the provisions of section 6, chapter 974, Oregon Laws 2001.

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

Stat. Auth.: Section 6, chapter 974, Oregon Laws 2001, ORS 656.726(4)
Stats. Implemented: Section 6, chapter 974, Oregon Laws 2001
Hist.: Adopted 12/6/01 as WCD Admin. Order 01-063, eff. 1/1/02

436-150-0005 Definitions

As used in OAR 436-150-0001 through 436-150-0040, unless the context requires otherwise:

(1) "Compensation," for the purposes of this program, means temporary and permanent disability due injured workers pursuant to ORS chapter 656, and out-of-pocket expenses for injured workers in accordance with OAR 436-009-0025, such as prescription and mileage reimbursements. Compensation does not include amounts payable to providers, or benefits payable pursuant to claim settlements or claim disposition agreements.

(2) "Default" means an insurer has failed to make payments of compensation due injured workers pursuant to ORS chapter 656 for which there is no dispute over the right of the worker to receive such compensation or the amount therein.

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

(4) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(5) "Insurer" means an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in this state.

(6) "Oregon Insurance Guaranty Association" or "OIGA" means the association created by ORS 734.550.

(7) "Paying Agency" means the insurer, or the insurer's authorized representative, responsible for paying compensation due under ORS chapter 656.

Stat. Auth.: ORS 656.445, 656.726(4)
Stats. Implemented: ORS 656.445
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-062, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-150-0006 Administration of Rules

Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and these rules are considered orders of the director.

Stat. Auth.: Section 6, chapter 974, Oregon Laws 2001, ORS 656.726(4)
Stats. Implemented: Section 6, chapter 974, Oregon Laws 2001
Hist.: Adopted 12/6/01 as WCD Admin. Order 01-063, eff. 1/1/02

436-150-0008 Administrative Review

(1) Any party as defined by ORS 656.005, and including the Oregon Insurance Guaranty Association, aggrieved by a proposed order or proposed assessment of civil penalty of the director or division issued pursuant to ORS 656.745 or 656.750 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

(a) The request for hearing must be sent in writing to the Administrator of the Workers' Compensation Division. No hearing shall be granted unless the request specifies the grounds upon which the person requesting the hearing contests the proposed order or assessment.

(b) The request for hearing must be filed with the Administrator of the Workers' Compensation Division by the aggrieved person within 60 days after the mailing date of the proposed order or assessment. No hearing will be granted unless the request is mailed or delivered to the administrator within 60 days after the mailing date of the proposed order or assessment.

(2) Under ORS 656.704(2), any party that disagrees with an action or order of the director under these rules, other than as described in section (1) of this rule, may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 656.445, 656.726(4)
Stats. Implemented: ORS 656.445, 656,704, 656.740, OL 2005 ch 26
Hist.: Amended 10/19/05 as WCD Admin. Order 05-070, eff. 1/2/06

See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-150-0010 Criteria for Eligibility

(1) In order for the director to authorize expenditures from the Workers' Benefit Fund Claims Program there must be:

(a) Verification from an authority from the insurer's state of domicile that the insurer responsible for payment of compensation is in default, such as a notice of voluntary or involuntary rehabilitation, conservatorship, or other information indicating the insurer cannot or will not make payments of compensation; and

(b) An order of the director authorizing disbursements to injured workers from the Workers' Benefit Fund Claims Program. The order shall specify the qualifying claims, duration of payment obligation, and maximum expenditure limitation. The maximum expenditure limitation may not exceed the amount of securities on deposit for the insurer pursuant to ORS 731.628.

(2) When expenditures are authorized pursuant to section (1) of this rule, the paying agency shall provide the director with sufficient information, as specified in OAR 436-150-0030(2), to enable the director to advance funds to eligible injured workers.

(3) To be eligible for payment under the program:

(a) Compensation must be due and payable pursuant to ORS chapter 656; and

(b) There must be a record of an insurance policy on file with the director by the insurer covering the employer on the date of injury.

(4) Payments to eligible injured workers in accordance with these rules shall be applied toward the insurer's payment obligations under ORS chapter 656 and will be deducted from compensation due, pursuant to ORS 734.570.

Stat. Auth.: ORS 656.445, 656.726(4); Stats. Implemented: ORS 656.445
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-062, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-150-0020 Limitation of Program

(1) Payment of compensation shall be limited to the amount of securities on deposit for the insurer pursuant to ORS 731.628 and only to the extent the monies are available in the Workers' Benefit Fund.

(2) Payments for individual claims shall be limited to compensation that becomes due and payable during the period of default.

(3) Notwithstanding any other provision of these rules, the director may, in the director's discretion, authorize additional benefits for specific claims in cases of extreme hardship.

(4) In the event of insufficient funds in the Workers' Benefit Fund, the director shall have final authority to determine an equitable distribution, which will proportionately distribute the available funds among the claims having qualified for reimbursement under the Program.

Stat. Auth.: Section 6, chapter 974, Oregon Laws 2001, ORS 656.726(4)
Stats. Implemented: Section 6, chapter 974, Oregon Laws 2001
Hist.: Adopted 12/6/01 as WCD Admin. Order 01-063, eff. 1/1/02

436-150-0030 Payment of Benefits

(1) Payment of compensation may be made by the director after receipt of documentation that compensation is due and payable.

(2) Documentation to support payment from the Workers' Benefit Fund Claims Program shall be submitted by the paying agent to include, but not be limited to:

(a) Insurer name, address, and policy number;

(b) Injured worker name, address, insurer claim number, Workers' Compensation Division claim number, and date of injury;

(c) Employer name and address;

(d) Amount, duration, and purpose of compensation due;

(e) Amounts payable for support pursuant to ORS 656.234, along with supporting documentation; and

(f) Any other information deemed necessary by the director.

Stat. Auth.: ORS 656.445, 656.726(4); Stats. Implemented: ORS 656.445
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-062, eff. 1-1-2010
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-150-0040 Accounting and Repayment of Payment of Benefits

(1) The director shall establish an account of record to monitor all expenditures and transactions relating to the Workers' Benefit Fund Claims Program and these rules. The accounting shall provide a detailed record of payments to each injured worker and the respective insurer responsible for the claim to include, but not be limited to, information as specified in OAR 436-150-0030(2).

(2) When the obligation to make payment of compensation is assumed by the Oregon Insurance Guaranty Association (OIGA) due to the insolvency of an insurer, the OIGA shall reimburse the Workers' Benefit Fund for all moneys advanced to injured workers for covered claims, as specified by OAR 734.510(4) and these rules. The OIGA shall reimburse the director within 60 days of receipt of sufficient information necessary to support the covered claims. All moneys received from the OIGA by the director shall be placed into the Workers' Benefit Fund.

(3) If an insurer defaults in its payments to injured workers, but later resumes its obligation to make payments, the insurer shall reimburse the director for any moneys paid to the injured worker. Such payment shall be in such amounts and at such intervals as prescribed by an order of the director. Failure of the insurer to comply with the order of the director may result in civil penalty pursuant to ORS 656.745.

(4) Any dispute over an amount owing the director in accordance with these rules shall be resolved pursuant to OAR 436-150-0008(2).

Stat. Auth.: Section 6, chapter 974, Oregon Laws 2001, ORS 656.726(4)
Stats. Implemented: Section 6, chapter 974, Oregon Laws 2001
Hist.: Adopted 12/6/01 as WCD Admin. Order 01-063, eff. 1/1/02

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
ELECTRONIC DATA INTERCHANGE; MEDICAL BILL DATA

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 160
ELECTRONIC DATA INTERCHANGE
MEDICAL BILL DATA

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436-160-0001 Authority, Applicability, Purpose, and Administration of these Rules

(1) These rules are promulgated under the director's authority contained in ORS 656.726(4).

(2) These rules apply to workers' compensation related transactions filed with the director by electronic data interchange (EDI) on or after Oct. 1, 2014.

(3) The purpose of these rules is to require workers' compensation medical bill data reporting by electronic data interchange.

(4) Orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 are considered orders of the director.

(5) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Authority: ORS 656.264 and 656.726(4)
Stat. Implemented: ORS ch. 84, 656.264
Hist: Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-160-0004 Adoption of Standards

(1)(a) The director adopts, by reference, IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 2.0, dated Feb 1, 2014.

(b) The director adopts, by reference, the ASC X12 Implementation Acknowledgment for Health Care Insurance (999), dated February 2011.

(2) The form, format, and delivery of data elements reported and definitions will conform to the standards adopted under section (1), unless otherwise provided in these rules.

(3) Copies of the guides in section (1) are available for review during regular business hours at the Workers' Compensation Division, Operations Section, 350 Winter Street NE, Salem OR 97301, 503-947-7717.

(a) IAIABC members may view a copy of the Release 2.0 guide, or non-members may purchase a copy at the IAIABC website: http://www.iaiabc.org.

(b) The ASC X12 999 guide is available for purchase at the X12 online store: http://store.x12.org/store/healthcare-5010-consolidated-guides.

Stat. Authority: ORS 656.264; Stat. Implemented: ORS 656.264
Hist: Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-160-0005 General Definitions

For the purpose of these rules, unless it conflicts with statute or rule:

(1) "ANSI" means the American National Standards Institute.

(2) "ASC X12" means the Accredited Standards Committee chartered by the American National Standards Institute (http://www.x12.org/x12org/index.cfm).

(3) "Director" means the Director of the Department of Consumer and Business Services or the director's designee for the matter.

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

(5) "Electronic data interchange" or "EDI" means a computer to computer exchange of information in a standardized electronic format.

(6) "Electronic record" means information created, generated, sent, communicated, received, or stored by electronic means.

(7) "Exclude (not applicable to the transaction)" means the data element must not be sent or cannot be sent.

(8) "Fatal Technical" means the transaction set or item structurally requires the data element.

(9) "FEIN" means the federal employer identification number or other federal reporting number used by the insurer, insured, or employer for federal tax reporting purposes.

(10) "Header record" means the record that precedes each transmission for the purpose of identifying a sender, the date and time of the transmission, and the transaction set within the transmission.

(11) "Health Care Provider" has the same meaning as "medical provider," under OAR 436-010-0005(28).

(12) "IAIABC" means the International Association of Industrial Accident Boards and Commissions, a professional trade association comprised of state workers' compensation regulators and insurance representatives (www.iaiabc.org).

(13) "If Applicable/Available with Item Accept if Invalid" means the data element must be sent if appropriate for the item

record. Even if the item record has an invalid value, the transaction set or item record will not be rejected.

(14) "If Applicable/Available with Item Reject if Invalid" means the data element must be sent if appropriate for the item record. If the item record has an invalid value, then the transaction set or item record will be rejected.

(15) "Information" means data, text, images, sounds, codes, computer programs, software, databases, or the like.

(16) "Insurer" means the State Accident Insurance Fund Corporation, an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon, an assigned claims agent selected by the director under ORS 656.054, or a self-insured employer.

(17) "Mandatory data element" means an element that will cause a rejection of a transaction if the data element is omitted or submitted in an invalid format, or with an improper value.

(18) "Mandatory Conditional" means the data element is required when certain conditions are present.

(19) "Medical Bill" means a statement of charges for medical services, specified as "compensable medical services," under ORS 656.245.

(20) "Not Applicable" means the data element is not relevant, appropriate, or doesn't apply, although if present with an improper value will not cause a rejection of a transaction.

(21) "Record" means electronic record.

(22) "Trading partner" means the entity sending electronic data interchange (EDI) transactions to the division. Trading partners may include vendors or insurers.

(23) "Trailer record" means the record that designates the end of a transmission and provides a count of transactions contained within the transmission, not including the header and trailer records.

(24) "Transaction" means a set of EDI records, defined according to standards in OAR 436-160-0004.

(25) "Transmission" means a defined set of transactions, including both header and trailer records to be sent to the division or sender by EDI.

Stat. Authority: ORS 656.264 and ORS 656.726(4);
Stat. Implemented: ORS 84.004 and ORS 656.264
Hist: Amended 6/5/14 as WCD AO 14-057, eff. 7/1/14 (temp rule - repealed 7/10/14)
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-160-0040 Recognized Received Date

An electronic record is received when:

(1) The record enters the division's designated information processing system;

(2) All the required data elements and electronic records are in the form and format specified in these rules in the proper sequence; and

(3) The record can be fully processed by the division's information processing system.

Stat. Authority: ORS 656.264 and ORS 656.726(4)
Stat. Implemented: ORS 84.043 and ORS 656.264
Hist: Amended 9/17/08 as Admin. Order 08-062, eff. 7/1/09
Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD Admin. Order 14-057, eff. 7/1/14 (temp rule - repealed 7/10/14)
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-160-0060 Testing Procedures and Requirements

Testing and transition to production:

(1) Before testing can begin, or the division can accept medical billing data, the trading partner must submit a completed Medical Billing Data EDI Trading Partner Profile (Form 4015) to the division's EDI Coordinator. Form 4015 is available on the division's website: http://wcd.oregon.gov/insurer/edi/Pages/medical-bill-data.aspx.

(2) For test purposes each transmission must conform to the standards specified in OAR 436-160-0004.

(3) Test files will be evaluated in terms of whether the data sent was received in the correct standardized format and fully processed by the division's information processing system.

(4) The EDI Coordinator will determine the number of required transactions per test submission based on the anticipated volume of production transactions.

(5) To be approved to send production transmissions, the sender must:

(a) Accomplish secure file transfer protocol (SFTP) uploads and downloads;

(b) Demonstrate the ability to send transmissions to the division that are in the correct format and can be processed through the division's information processing system;

(c) Resolve any consistently recurring errors, and demonstrate the ability to correct and resubmit corrections to errors identified by the division;

(d) Send transmissions to the division that do not result in a 999 acknowledgment indicating a rejection;

(e) Send transmissions to the division without transaction level technical errors;

(f) Demonstrate the ability to receive and process acknowledgement transactions; and

(g) Achieve an acceptance rate of at least 90 percent.

Stat. Authority: ORS 656.726(4);
Stat. Implemented: ORS 84.013 and ORS 656.264
Hist: Amended 6/5/14 as WCD AO 14-057, eff. 7/1/14 (temp rule - repealed 7/10/14)
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-160-0405 Insurers' Reporting Responsibilities

(1) Insurers with an average of at least 100 accepted disabling claims per year, based on the average accepted disabling claim volume for the previous three calendar years, are required to electronically submit detailed medical bill payment data to the Department of Consumer and Business Services under OAR 436-160-0415.

(2) The director will notify an insurer when the insurer has reached a three-year average accepted disabling claim count of at least 100. The insurer is required to report medical bill payment data beginning with the date specified in the notice and must continue to report in subsequent years.

(3) If the insurer's claim count drops below an average of 50 accepted disabling claims, based on the average accepted

disabling claim volume for the previous three calendar years, insurers may apply to the director for an exemption from the reporting requirement.

(4) The list of insurers required to report medical bill data is published in Bulletin 359.

(5) Insurers that do not meet the requirement to submit medical data under (1) of this rule may voluntarily submit medical billing data.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Amended 6/5/14 as WCD AO 14-057, eff. 7/1/14 (temp rule - repealed 7/10/14)
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-160-0410 Electronic Medical Bill Data Transmission and Format Requirements

(1) The transmission data and format requirements are included in the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 2.0 (Feb 1, 2014), and Appendices A and B of these rules. Oregon-specific information can be found on the division's Electronic Data EDI webpage: http://wcd.oregon.gov/insurer/edi/Pages/medical-bill-data.aspx.

(2) Data elements are listed in Appendices A and B:

(a) Appendix A shows all medical bill data elements accepted by EDI in Oregon, and whether the data element is "Fatal Technical" (F), "Mandatory" (M), "Mandatory Conditional" (MC), "If Applicable/Available with Item Reject if Invalid" (AR), or "If Applicable/Available with Item Accept if Invalid" (AA) for each transaction type.

(b) Appendix B lists mandatory conditional data elements that are mandatory under specific conditions.

(3) Unless otherwise provided in these rules, the data elements must have the meaning provided in the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 2.0, dated Feb. 1, 2014, Section 2; Health Care Claim (837).

(4) Transactions will be rejected if "Fatal Technical," "Mandatory," or "Mandatory Conditional" data elements are omitted, or include invalid values.

(5) Transactions will be rejected if "If Applicable/Available with Item Reject if Invalid" data elements include invalid values.

(6) Invalid "If Applicable/Available with Item Accept if Invalid" data elements will be ignored if they are included in a transaction.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-160-0415 Oregon ASC X12 837 Medical Bill Data Reporting Requirements

(1) Event reporting requirements:

(a) Medical bills, including interpreter bills under OAR 436-009, must be reported within 60 days of the date paid.

(b) Denied medical bills for accepted claims must be reported within 60 days of date of denial. Denied bills are defined as any bills in which there is a non-zero charge and a zero payment.

(c) Transactions must be received and accepted by the division within 60 days of either the date paid or the date denied to be considered timely reported. If a transaction is initially rejected it must be corrected, resubmitted, and accepted within the original 60 day time period to be considered timely reported.

(d) Cancellations must be reported as soon as the payer knows that a medical bill was sent in error.

(e) Corrections/Replacements must be reported within 60 days of changes to any of the "Fatal Technical," "Mandatory," or "Mandatory Conditional" data elements in Appendices A and B.

(f) Bills received by the insurer before Oct. 1, 2014, may be reported to the Division using the IAIABC reporting standard version 1.1.

(2) Data reporting requirements are described in Appendices A and B.

(3) Technical requirements are described on the division's Electronic Data EDI webpage for specifications on the Secure File Transfer Protocol (SFTP) requirements.

(4) Data Quality: The director will conduct electronic edits for blank or invalid data. Affected insurers are responsible for pre-screening the data they submit to check that all the required information is reported and is formatted correctly. OAR 436-160-0420 describes the acceptance or rejection protocol for all reported medical bills. The insurer is responsible for timely correcting and resubmitting all rejected transactions for which law or rule require filing, reporting, or notice to the director.

(5) An insurer must request and receive authorization from the director to stop submitting a previously rejected transaction when the division determines the transaction is uncorrectable.

(6) The director will periodically review reported bill data to monitor insurer performance. If the director finds repeated or egregious violations of the reporting requirements of these rules the director may issue civil penalties under OAR 436-160-0445 and ORS 656.745.

(a) Medical bills must be reported timely. "Timely" means that an insurer reports medical bills as required by OAR 436-160-0415(1).

(b) Medical bills must be reported accurately. "Accurately" means that the reported medical bill data accepted by the division conforms to the reporting requirements of the Appendices A and B.

(c) The insurer may be subject to penalties for any reported medical bills that have not been accepted by the division or designated as uncorrectable under OAR 436-160-0415(5) within 180 days of the date of bill payment or denial.

Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 656.264
Hist: Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-160-0420 Medical Bill Acknowledgement

(1)(a) The sender is expected to retrieve both TA1 and 999 interchange and functional acknowledgements (as defined by ASC X12) for each medical bill file submitted, unless technical errors in the file prevent 999 processing. In addition, the sender is expected to retrieve the 824 detailed acknowledgement, as defined by IAIABC Release 2.0 (Feb.1, 2014) for each medical bill file submitted, if at least one transaction has successfully passed the 999 edits.

(b) The detailed acknowledgement will indicate either an item accepted (IA) or an item rejected (IR) acknowledgement for each individual transaction.

(2) A TA1, 999 or 824 acknowledgement will be available for all transactions the division is unable to process, including but not limited to:

(a) An omitted mandatory data element;

(b) An improperly populated data element field, e.g., numeric data element field is populated with alpha or alphanumeric data, or is not a valid value according to the standards adopted in 436-160-0004;

(c) Transactions or electronic records within the transaction that require matching, and cannot be matched to the division's database, e.g., cancellation of an original bill that does not match the Unique Bill ID;

(d) Illogical data in mandatory or required conditional field, e.g., payment date is after reporting date;

(e) Duplicate transmission or duplicate transaction within the transmission;

(f) Invalid bill submission reason code; or

(g) Illogical event sequence relationship between transactions, e.g., cancellation transaction submitted before an original bill is accepted.

(3) A transaction accepted acknowledgement will be available for all transactions that are in a format capable of being processed by the division's information processing system and that are not rejected under section (2) of this rule.

(4) An insurer's obligation to report medical bill data for the purposes of this rule is not satisfied unless the division acknowledges acceptance of the transaction.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-160-0430 Medical Bill Data Changes

(1) Changes to medical bill information must be submitted according to the standards referenced in OAR 436-160-0004.

(2) The Unique Bill ID will be used to match cancellations, corrections, and replacements to the original bill. Failure to match on this data element will result in a rejected transaction.

(3) The insurer must correct and resubmit any transactions rejected for which law or rule requires filing, reporting, or notice to the director.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Amended 6/5/14 as WCD AO 14-057, eff. 7/1/14 (temp rule - repealed 7/10/14)
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-160-0440 Monitoring and Auditing Insurers

(1) The director may monitor and conduct periodic audits of medical bill data to ensure compliance with ORS chapter 656 and these rules.

(2) All records maintained or required to be maintained must be disclosed upon request by the director.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.254, 656.264, 656.455, 656.726
Hist: Amended 6/5/14 as WCD AO 14-057, eff. 7/1/14 (temp rule - repealed 7/10/14)
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-160-0445 Assessment of Civil Penalties

(1) Under ORS 656.745, the director may assess a civil penalty against an insurer that fails to comply with ORS chapter 656 or the director's rules and orders.

(2) The insurer is responsible for its own actions as well as the actions of others acting on the insurer's behalf. If an insurer or someone acting on the insurer's behalf violates any provisions of these rules, the director may impose a civil penalty against the insurer.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.254, 656.745
Hist: Amended 6/5/14 as WCD AO 14-057, eff. 7/1/14 (temp rule - repealed 7/10/14)
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

Appendix A and Appendix B (OAR 436-160-0410)

Requirement Codes (for Appendix A)	
F	Fatal Technical
M	Mandatory
MC	Mandatory Conditional: Conditions are defined on the Medical Conditions Table, Appendix B
AA	If Applicable/Available with Item Accept if Invalid
AR	If Applicable/Available with Item Reject if Invalid
NA	Not Applicable
X	Exclude (not applicable to the transaction)

Oregon Medical EDI Element Requirement Table - Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Transaction Set Header - Required Loop																		
0532	BHT03	ORIGINATOR TRANSACTION IDENTIFICATION NUMBER	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0100	BHT04	DATE TRANSMISSION SENT	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0101	BHT05	TIME TRANSMISSION SENT	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Loop ID 1000A - Submitter Information - Required Loop																		
0098	NM109	SENDER ID	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Loop ID 1000B - Receiver Information - Required Loop																		
0099	NM109	RECEIVER ID	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Loop ID 2000A - Insurer Hierarchical Level Information - Required Loop																		
0615	DTP03	REPORTING PERIOD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Loop ID 2010AA - Insurer/Self Insured Information - Required Loop																		
0007	NM103	INSURER NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0006	NM109	INSURER FEIN	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0616	N403	INSURER POSTAL CODE	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Loop ID 2010AB - Claim Administrator Information - Situational Loop																		
0188	NM103	CLAIM ADMINISTRATOR NAME	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0187	NM109	CLAIM ADMINISTRATOR FEIN	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0014	N403	CLAIM ADMINISTRATOR MAILING POSTAL CODE	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
Loop ID 2010BA - Employer Information - Required Loop																		
0018	NM103	EMPLOYER NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0016	NM109	EMPLOYER FEIN	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0019	N301	EMPLOYER PHYSICAL PRIMARY ADDRESS	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0020	N302	EMPLOYER PHYSICAL SECONDARY ADDRESS	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0021	N401	EMPLOYER PHYSICAL CITY	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0022	N402	EMPLOYER PHYSICAL STATE CODE	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0023	N403	EMPLOYER PHYSICAL POSTAL CODE	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0164	N404	EMPLOYER PHYSICAL COUNTRY CODE	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
Loop ID 2000C - Claimant Hierarchical Information - Required Loop																		
0031	DTP03	DATE OF INJURY	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F

Oregon Medical EDI Element Requirement Table - Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2010CA - Claimant Information - Required Loop																		
0043	NM103	EMPLOYEE LAST NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0044	NM104	EMPLOYEE FIRST NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0045	NM105	EMPLOYEE MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0255	NM107	EMPLOYEE LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0042	NM109	EMPLOYEE SSN	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0153	NM109	EMPLOYEE GREEN CARD	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0154	NM109	EMPLOYEE ID ASSIGNED BY JURISDICTION	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0156	NM109	EMPLOYEE PASSPORT NUMBER	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0152	NM109	EMPLOYEE EMPLOYMENT VISA	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0046	N301	EMPLOYEE MAILING PRIMARY ADDRESS	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0047	N302	EMPLOYEE MAILING SECONDARY ADDRESS	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0048	N401	EMPLOYEE MAILING CITY	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0049	N402	EMPLOYEE MAILING STATE CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0050	N403	EMPLOYEE MAILING POSTAL CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0155	N404	EMPLOYEE MAILING COUNTRY CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0052	DMG02	EMPLOYEE DATE OF BIRTH	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0053	DMG03	EMPLOYEE GENDER CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0015	REF02	CLAIM ADMINISTRATOR CLAIM NUMBER	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0015	REF02	REPLACEMENT CLAIM ADMINISTRATOR CLAIM NUMBER	NA	NA	AA	AA	NA	NA	AA	AA	NA	NA	AA	AA	NA	NA	AA	AA
0005	REF02	JURISDICTION CLAIM NUMBER	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0051	PER04	EMPLOYEE PHONE NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Oregon Medical EDI Element Requirement Table - Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2300 - Bill Information - Required Loop																		
0523	CLM01	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0501	CLM02	TOTAL CHARGE PER BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0502	CLM04	BILLING TYPE CODE	X	NA	X	X	X	NA	X	X	X	NA	X	X	X	NA	X	X
0504	CLM05-1	FACILITY CODE	X	NA	X	X	F	F	F	F	X	NA	X	X	X	NA	X	X
0555	CLM05-1	PLACE OF SERVICE BILL CODE	F	F	F	F	X	X	X	X	F	F	F	F	F	F	F	F
0503	CLM05-2	BILLING FORMAT CODE	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0505	CLM05-3	BILL FREQUENCY TYPE CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0507	CLM16	PROVIDER AGREEMENT CODE*	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0508	CLM19	BILL SUBMISSION REASON CODE	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0511	DTP03	DATE INSURER RECEIVED BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0513	DTP03	ADMISSION DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0622	DTP03	ADMISSION HOUR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0514	DTP03	DISCHARGE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0623	DTP03	DISCHARGE HOUR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0509	DTP03	SERVICE BILL DATE(S) RANGE	NA	NA	NA	NA	M	NA	M	M	NA	NA	NA	NA	NA	NA	NA	NA
0527	DTP03	PRESCRIPTION DATE(s)	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0510	DTP03	DATE OF BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0512	DTP03	DATE INSURER PAID BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0577	CL101	ADMISSION TYPE CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0515	CN101	CONTRACT TYPE CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0516	AMT02	TOTAL AMOUNT PAID PER BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0500	REF02	UNIQUE BILL ID NUMBER	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0266	REF02	TRANSACTION TRACKING NUMBER	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0581	REF02	TREATMENT AUTHORIZATION NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0293	REF02	LUMP SUM PAYMENT/SETTLEMENT CODE	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

*** Enter "P" if worker is enrolled in a WCD-certified managed care organization (MCO) at time of service or if provider participates in a WCD-registered fee discount agreement. Enter "H" if care was provided through a health maintenance organization (HMO). Enter "Y" for any other agreement. Enter "N" for none.**

Oregon Medical EDI Element Requirement Table - Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
HI Segment - Institutional Bill Principal Diagnosis - Situational Segment																		
0521	HI01-2	PRINCIPAL DIAGNOSIS CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0533	HI01-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
HI Segment - Institutional Bill Admitting Diagnosis - Situational Segment																		
0535	HI01-2	ADMITTING DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
HI Segment - Institutional Bill Other Diagnosis - Situational Segment																		
0522	HI01-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI01-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI02-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI02-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI03-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI03-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI04-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI04-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI05-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI05-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI06-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI06-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI07-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI07-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI08-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI08-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI09-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI09-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI10-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI10-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI11-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI11-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI12-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI12-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X

Oregon Medical EDI Element Requirement Table - Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
HI Segment - Outpatient Reason For Visit - Situational Segment																		
0520	HI01-2	OUTPATIENT REASON FOR VISIT CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0520	HI02-2	OUTPATIENT REASON FOR VISIT CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0520	HI03-2	OUTPATIENT REASON FOR VISIT CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
HI Segment - Non-Institutional Diagnosis Codes - Situational Segment																		
0521	HI01-2	PRINCIPAL DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI02-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI03-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI04-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
HI Segment - Non-Institutional Diagnosis Codes - Situational Segment																		
0522	HI05-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI06-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI07-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI08-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI09-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI10-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI11-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI12-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
HI Segment - Institutional Bill Principal Procedure - Situational Segment																		
0525	HI01-2	PRINCIPAL PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0550	HI01-4	PRINCIPAL PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X

Oregon Medical EDI Element Requirement Table - Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
HI Segment - Institutional Bill Other Procedure Codes - Situational Segment																		
0736	HI01-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI01-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI02-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI02-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI03-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI03-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI04-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI04-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI05-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI05-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI06-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI06-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI07-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI07-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI08-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI08-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI09-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
HI Segment - Institutional Bill Other Procedure Codes - Situational Segment																		
0524	HI09-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI10-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI10-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI11-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI11-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI12-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI12-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X

Oregon Medical EDI Element Requirement Table - Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
HI Segment - Condition Codes - Situational Segment																		
0556	HI01-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI02-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI03-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI04-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI05-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI06-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI07-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI08-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI09-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI10-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI11-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI12-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
HI Segment - Diagnosis Related Group (DRG) Information - Situational Segment																		
0549	HI01-2	PAID DRG CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0548	HI01-8	BILLED DRG CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
Loop ID 2310A - Billing Provider Information - Required Loop																		
0528	NM103	BILLING PROVIDER LAST/GROUP NAME	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0529	NM104	BILLING PROVIDER FIRST NAME	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0530	NM105	BILLING PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0531	NM107	BILLING PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0634	NM109	BILLING PROVIDER NATIONAL PROVIDER ID	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR

Oregon Medical EDI Element Requirement Table - Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2310A - Billing Provider Information - Required Loop																		
0537	PRV03	BILLING PROVIDER PRIMARY SPECIALTY CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0538	N301	BILLING PROVIDER PRIMARY ADDRESS	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0539	N302	BILLING PROVIDER SECONDARY ADDRESS	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0540	N401	BILLING PROVIDER CITY	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0541	N402	BILLING PROVIDER STATE CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0542	N403	BILLING PROVIDER POSTAL CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0569	N404	BILLING PROVIDER COUNTRY CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0629	REF02	BILLING PROVIDER FEIN	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0630	REF02	BILLING PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2310B - Rendering Bill Provider Information - Situational Loop																		
0638	NM103	RENDERING BILL PROVIDER LAST/GROUP NAME	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0639	NM104	RENDERING BILL PROVIDER FIRST NAME	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0640	NM105	RENDERING BILL PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0641	NM107	RENDERING BILL PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0647	NM109	RENDERING BILL PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	M	NA	M	M	MC	NA	MC	MC	MC	NA	MC	MC
0651	PRV03	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
0643	REF02	RENDERING BILL PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2310C - Supervising Provider Information - Situational Loop																		
0658	NM103	SUPERVISING PROVIDER LAST/GROUP NAME	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0659	NM104	SUPERVISING PROVIDER FIRST NAME	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0660	NM105	SUPERVISING PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0661	NM107	SUPERVISING PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0667	NM109	SUPERVISING PROVIDER NATIONAL PROVIDER ID	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0671	PRV03	SUPERVISING PROVIDER PRIMARY SPECIALTY CODE	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0663	REF02	SUPERVISING PROVIDER STATE LICENSE NUMBER	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X

Oregon Medical EDI Element Requirement Table - Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2310D - Service Facility Location Information - Situational Loop																		
0678	NM103	FACILITY NAME	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0682	NM109	FACILITY NATIONAL PROVIDER ID	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0684	N301	FACILITY PRIMARY ADDRESS	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0685	N302	FACILITY SECONDARY ADDRESS	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0686	N401	FACILITY CITY	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0687	N402	FACILITY STATE CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0688	N403	FACILITY POSTAL CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0689	N404	FACILITY COUNTRY CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0680	REF02	FACILITY STATE LICENSE NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0683	REF02	FACILITY SERVICE LOCATION ID	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
Loop ID 2310E - Referring Provider Information - Situational Loop																		
0690	NM103	REFERRING PROVIDER LAST/GROUP NAME	NA	NA	NA	NA	NA	NA	NA	NA	M	NA	M	M	NA	NA	NA	NA
0691	NM104	REFERRING PROVIDER FIRST NAME	NA	NA	NA	NA	NA	NA	NA	NA	MC	NA	MC	MC	NA	NA	NA	NA
0692	NM105	REFERRING PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0693	NM107	REFERRING PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0699	NM109	REFERRING PROVIDER NATIONAL PROVIDER ID	NA	NA	NA	NA	NA	NA	NA	NA	MC	NA	MC	MC	NA	NA	NA	NA
0695	REF02	REFERRING PROVIDER STATE LICENSE NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	MC	NA	MC	MC	NA	NA	NA	NA
Loop ID 2310F - Managed Care Organization Information - Situational Loop																		
0209	NM103	MANAGED CARE ORGANIZATION NAME	~~NA~~ MC	NA	~~NA~~ MC	~~NA~~ MC	~~NA~~ MC	NA	~~NA~~ MC	~~NA~~ MC	~~NA~~ MC	NA	~~NA~~ MC	~~NA~~ MC	~~NA~~ MC	NA	~~NA~~ MC	~~NA~~ MC
0208	NM109	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0704	REF02	MANAGED CARE ORGANIZATION FEIN	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Oregon Medical EDI Element Requirement Table - Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2320 - Bill Level Adjustments and Amounts - Situational Loop																		
0543	CAS01	BILL ADJUSTMENT GROUP CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0544	CAS02	BILL ADJUSTMENT REASON CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0545	CAS03	BILL ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0546	CAS04	BILL ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0544	CAS05	BILL ADJUSTMENT REASON CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0545	CAS06	BILL ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0546	CAS07	BILL ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0544	CAS08	BILL ADJUSTMENT REASON CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0545	CAS09	BILL ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0546	CAS10	BILL ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0760	AMT02	PRIOR ACTUAL AMOUNT PAID	X	X	X	NA	X	X	X	NA	X	X	X	NA	X	X	X	NA
Loop ID 2400 - Service Line Information - Situational Loop																		
0547	LX01	LINE NUMBER	F	NA	F	F	F	NA	F	F	F	NA	F	F	F	NA	F	F
0714	SV101-2	HCPCS LINE PROCEDURE BILLED CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0715	SV101-2	JURISDICTION PROCEDURE BILLED CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0721	SV101-2	NDC BILLED CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-3	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-3	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-4	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-4	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-5	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-5	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-6	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-6	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0551	SV101-7	PROCEDURE DESCRIPTION	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0552	SV102	TOTAL CHARGE PER LINE	M	NA	M	M	X	X	X	X	X	X	X	X	X	X	X	X

Oregon Medical EDI Element Requirement Table - Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2400 - Service Line Information - Situational Loop																		
0553	SV103	DAYS(S)/UNIT(S) CODE	M	NA	M	M	X	X	X	X	X	X	X	X	X	X	X	X
0554	SV104	DAY(S) /UNIT(S) BILLED	M	NA	M	M	X	X	X	X	X	X	X	X	X	X	X	X
0600	SV105	PLACE OF SERVICE LINE CODE	AR	NA	AR	AR	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-1	DIAGNOSIS POINTER	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-2	DIAGNOSIS POINTER	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-3	DIAGNOSIS POINTER	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-4	DIAGNOSIS POINTER	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0742	SV121	PROVIDER AGREEMENT LINE CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0559	SV201	REVENUE BILLED CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0714	SV202-2	HCPCS LINE PROCEDURE BILLED CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0625	SV202-2	HIPPS RATE CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0715	SV202-2	JURISDICTION PROCEDURE BILLED CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0717	SV202-3	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-3	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0717	SV202-4	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-4	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0717	SV202-5	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-5	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0717	SV202-6	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-6	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0551	SV202-7	PROCEDURE DESCRIPTION	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0552	SV203	TOTAL CHARGE PER LINE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0553	SV204	DAYS(S)/UNIT(S) CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0554	SV205	DAY(S) /UNIT(S) BILLED	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0719	SV301-2	ADA PROCEDURE BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0714	SV301-2	HCPCS LINE PROCEDURE BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC

Oregon Medical EDI Element Requirement Table - Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2400 - Service Line Information - Situational Loop																		
0717	SV301-3	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0717	SV301-4	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0717	SV301-5	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0717	SV301-6	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0551	SV301-7	PROCEDURE DESCRIPTION	X	X	X	X	X	X	X	X	X	X	X	X	NA	NA	NA	NA
0552	SV302	TOTAL CHARGE PER LINE	X	X	X	X	X	X	X	X	X	X	X	X	M	NA	M	M
0600	SV303	PLACE OF SERVICE LINE CODE	X	X	X	X	X	X	X	X	X	X	X	X	AR	NA	AR	AR
0742	SV309	PROVIDER AGREEMENT LINE CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0561	SV401	PRESCRIPTION LINE NUMBER	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0721	SV402-2	NDC BILLED CODE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0562	SV405	DISPENSE AS WRITTEN CODE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0563	SV408	DRUG NAME	X	X	X	X	X	X	X	X	NA	NA	NA	NA	X	X	X	X
0762	SV410	COMPOUND DRUG INDICATOR	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0605	DTP03	SERVICE LINE DATE(S) RANGE	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0604	DTP03	PRESCRIPTION LINE DATE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0570	QTY02	DRUGS/SUPPLIES QUANTITY DISPENSED	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0571	QTY02	DRUGS/SUPPLIES NUMBER OF DAYS	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0741	CN101	CONTRACT LINE TYPE CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0738	REF02	TREATMENT LINE AUTHORIZATION NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0579	AMT02	DRUGS/SUPPLIES DISPENSING FEE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0572	AMT02	DRUGS/SUPPLIES BILLED AMOUNT	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0627	AMT02	LINE ITEM TAX CHARGE AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2420 - Rendering Line Provider Information - Situational Loop																		
0589	NM103	RENDERING LINE PROVIDER LAST/GROUP NAME	AA	NA	AA	AA	NA	NA	NA	NA	AA	NA	AA	AA	AA	NA	AA	AA
0587	NM104	RENDERING LINE PROVIDER FIRST NAME	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
0591	NM105	RENDERING LINE PROVIDER MIDDLE NAME/INITIAL	AA	NA	AA	AA	NA	NA	NA	NA	AA	NA	AA	AA	AA	NA	AA	AA
0588	NM107	RENDERING LINE PROVIDER LAST NAME SUFFIX	AA	NA	AA	AA	NA	NA	NA	NA	AA	NA	AA	AA	AA	NA	AA	AA
0592	NM109	RENDERING LINE PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC

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		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2420 - Rendering Line Provider Information - Situational Loop																		
0595	PRV03	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
0599	REF02	RENDERING LINE PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop																		
0574	SVD02	TOTAL AMOUNT PAID PER LINE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0722	SVD03-2	ADA PROCEDURE PAID CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0726	SVD03-2	HCPCS LINE PROCEDURE PAID CODE	MC	NA	MC	MC	MC	NA	MC	MC	X	X	X	X	MC	NA	MC	MC
0728	SVD03-2	NDC PAID CODE	MC	NA	MC	MC	X	X	X	X	MC	NA	MC	MC	X	X	X	X
0729	SVD03-2	JURISDICTION PROCEDURE PAID CODE	MC	NA	MC	MC	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0727	SVD03-3	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-3	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0727	SVD03-4	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-4	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0727	SVD03-5	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-5	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0727	SVD03-6	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-6	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0576	SVD04	REVENUE PAID CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0580	SVD05	DAYS(S)/UNIT(S) PAID	AA	NA	AA	AA	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0547	SVD06	LINE NUMBER	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0731	CAS01	SERVICE ADJUSTMENT GROUP CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0732	CAS02	SERVICE ADJUSTMENT REASON CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0733	CAS03	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0734	CAS04	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0732	CAS05	SERVICE ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0733	CAS06	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC

Oregon Medical EDI Element Requirement Table - Appendix A

		Type of Medical Bill Record	Professional				Institutional				Pharmaceutical				Dental			
		Segment used to report a product or service	SV1				SV2				SV4				SV3			
		Bill Submission Reason Codes (BSRC)	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop																		
0734	CAS07	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0732	CAS08	SERVICE ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0733	CAS09	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0734	CAS10	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0732	CAS11	SERVICE ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0733	CAS12	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0734	CAS13	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0732	CAS14	SERVICE ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0733	CAS15	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0734	CAS16	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0761	AMT02	LINE ITEM PRIOR ACTUAL AMOUNT PAID	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0628	AMT02	LINE ITEM TAX PAID AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2010AB - Claim Administrator Information - Situational Loop					
MC	0188	NM103	CLAIM ADMINISTRATOR NAME	Required when the Claim Administrator is a different entity than the insurer or self-insured reported in Loop 2010AA/NM103/DN0007.	Required when NM101 equals "CX".
MC	0187	NM109	CLAIM ADMINISTRATOR FEIN	Required when the Claim Administrator is a different entity than the insurer or self-insured reported in Loop 2010AA/NM103/DN0007.	Required when DN0188 Claim Administrator Name is reported.
MC	0014	N403	CLAIM ADMINISTRATOR MAILING POSTAL CODE	Required when Claim Administrator information is reported in Loop 2010AB	Required when DN0188 Claim Administrator Name is reported.
Loop ID 2010CA - Claimant Information - Required Loop					
MC	0042	NM109	EMPLOYEE SSN	DN0042 Employee SSN is the preferred ID number. If none, see DN153 Employee Green Card. If injured worker has no other identification, use “999999999.”	Required when DN0153, DN0154, DN0156 and DN0152 are not reported.
MC	0153	NM109	EMPLOYEE GREEN CARD	Required when DN0042 Employee Social Security number is not available.	Required when DN0042, DN0154, DN0156 and DN0152 are not reported.
MC	0154	NM109	EMPLOYEE ID ASSIGNED BY JURISDICTION	Required when DN0042 Employee Social Security, DN0153 Employee Green Card, DN0152 Employee Employment Visa and DN0156 Employee Passport Number are not available.	Required when DN0042, DN0153, DN0156 and DN0152 are not reported.
MC	0156	NM109	EMPLOYEE PASSPORT NUMBER	Required when DN0042 Employee Social Security, DN0153 Employee Green Card, and DN0152 Employee Employment Visa are not available.	Required when DN0042, DN0153, DN0154 and DN0152 are not reported.
MC	0152	NM109	EMPLOYEE EMPLOYMENT VISA	Required when DN0042 Employee Social Security number and DN0153 Employee Green Card number are not available.	Required when DN0042, DN0153, DN0154 and DN0156 are not reported.
MC	0005	REF02	JURISDICTION CLAIM NUMBER	Required when the insurance carrier, claim administrator, or reporting entity has received the jurisdiction's assigned claim number.	Required when segment is used by jurisdiction and REF01 = Y4.

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2300 - Bill Information - Required Loop					
MC	0513	DTP03	ADMISSION DATE	Required when DN0504 Facility Code is an inpatient type, and either DN0516 Total Amount Paid Per Bill is not equal to 0; or DN0513 is on the bill.	Required when DN0504 Facility Code is one of the following: 11, 12, 18, 21, 22, 28, 41, 65, 66, 86, and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0513 is known.
MC	0514	DTP03	DISCHARGE DATE	Required on final inpatient medical bills.	Required when DN0505 Bill Frequency Type Code equals 1 or 4.
MC	0577	CL101	ADMISSION TYPE CODE	Required when DN0504 Facility Code is an inpatient type, and either DN0516 Total Amount Paid Per Bill is not equal to 0; or DN0577 is on the bill.	Required when DN0504 Facility Code is one of the following: 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89 and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0577 is known.
MC	0515	CN101	CONTRACT TYPE CODE	When DN0549 Paid DRG Code is present, this value must be 01 (DRG). Otherwise, this data element must be reported when the medical services are subject to contractual adjustments and the post-adjudication reimbursement was impacted by the contract, but not be 01.	When DN0549 (Paid DRG Code) is present, this value must be 01 (DRG). Otherwise, this data element must be reported when a contract impacts payment of the bill, but must not have a value of 01.
HI Segment - Institutional Bill Admitting Diagnosis - Situational Segment					
MC	0535	HI01-2	ADMITTING DIAGNOSIS CODE	Required when DN0504 Facility Code is an inpatient type, and either DN0516 Total Amount Paid Per Bill is not equal to 0; or DN0535 is on the bill.	Required when DN0504 Facility Code is one of the following: 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89 and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0535 is known.

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
HI Segment - Institutional Bill Other Diagnosis					
MC	0522	HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI09-2, HI10-2, HI11-2, HI12-2	DIAGNOSIS CODE	Required when this element is on the bill.	Required when the value of DN0522 is known.
HI Segment - Outpatient Reason For Visit - Situational Segment					
MC	0520	HI01-2	OUTPATIENT REASON FOR VISIT CODE	Required when DN0516 Total Amount Paid Per Bill is not equal to 0, and DN0504 Facility Code is either hospital outpatient, critical access hospital or licensed freestanding emergency medical facility type and DN0577 Admission Type Code describes the admission type as emergency, urgent or trauma and a reported DN0559 Revenue Billed Code equals one of the following values with or without a leading 0: 450, 451, 452, 456, 459, 516, 526, 762.	Required when DN0516 Total Amount Paid Per Bill is not equal to 0, and DN0504 Facility Code equals 13, 85, or 78 and DN0577 Admission Type Code equals 1, 2, or 5 and a reported DN0559 Revenue Billed Code equals one of the following values with or without a leading 0: 450, 451, 452, 456, 459, 516, 526, 762.
MC	0520	HI02-2	OUTPATIENT REASON FOR VISIT CODE	Required when DN0520 (HI01-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.	Required when DN0520 (HI01-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.
MC	0520	HI03-2	OUTPATIENT REASON FOR VISIT CODE	Required when DN0520 (HI02-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.	Required when DN0520 (HI02-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
HI Segment - Non-Institutional Diagnosis Codes - Situational Segment					
MC	0521	HI01-2	PRINCIPAL DIAGNOSIS CODE	Required when both DN0537 Billing Provider Primary Specialty Code and DN0651 Rendering Bill Provider Primary Specialty Code are not values excluded from diagnosing an injury or illness, any DN0721 NDC Billed Code or DN0714 HCPCS Line Procedure Billed Code not beginning with A0 is paid as billed, or any DN0728 NDC Paid Code is paid, or any DN0726 HCPCS Line Procedure Paid Code not beginning with A0 is paid; and DN0516 Total Amount Paid Per Bill is not equal to 0.	Required when both DN0537 Billing Provider Primary Specialty Code and DN0651 Rendering Bill Provider Primary Specialty Code are 1) not of the following types (Type Level 1 Provider Type) as defined by Washington Publishing Company: "Respiratory, Developmental, Rehabilitative and Restorative Service Providers," "Technologists, Technicians & Other Technical Service Providers," "Other Service Providers," "Transportation Services" and 2) not any of the classifications (Type Level II Classification) as defined by Washington Publishing Company are named "Ambulance," "Pharmacist," and "Pharmacy;" and any DN0721 NDC Billed Code or DN0714 HCPCS Line Procedure Billed Code not beginning with A0 is paid as billed, or any DN0728 NDC Paid Code is paid, or any DN0726 HCPCS Line Procedure Paid Code is paid; and DN0516 Total Amount Paid Per Bill is not equal to 0.
MC	0522	HI02-2	DIAGNOSIS CODE	Required when DN0521 Principal Diagnosis Code is required and there is another diagnosis.	Required when DN0521 Principal Diagnosis Code is required and there is another diagnosis.
MC	0522	HI03-2	DIAGNOSIS CODE	Required when DN0522 (HI02-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI02-2) Diagnosis Code is required and there is another diagnosis.

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
HI Segment - Non-Institutional Diagnosis Codes - Situational Segment					
MC	0522	HI04-2	DIAGNOSIS CODE	Required when DN0522 (HI03-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI03-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI05-2	DIAGNOSIS CODE	Required when DN0522 (HI04-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI04-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI06-2	DIAGNOSIS CODE	Required when DN0522 (HI05-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI05-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI07-2	DIAGNOSIS CODE	Required when DN0522 (HI06-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI06-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI08-2	DIAGNOSIS CODE	Required when DN0522 (HI07-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI07-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI09-2	DIAGNOSIS CODE	Required when DN0522 (HI08-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI08-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI10-2	DIAGNOSIS CODE	Required when DN0522 (HI09-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI09-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI11-2	DIAGNOSIS CODE	Required when DN0522 (HI10-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI10-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI12-2	DIAGNOSIS CODE	Required when DN0522 (HI11-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI11-2) Diagnosis Code is required and there is another diagnosis.
HI Segment - Institutional Bill Principal Procedure - Situational Segment					
MC	0550	HI01-4	PRINCIPAL PROCEDURE DATE	Required when DN0525 Principal Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0550 is known.	Required when DN0525 Principal Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0550 is known.

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
HI Segment - Institutional Bill Other Procedure Codes - Situational Segment					
MC	0524	HI01-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI01-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI02-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI02-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI03-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI03-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI04-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI04-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI05-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI05-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI06-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI06-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI07-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI07-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
HI Segment - Institutional Bill Other Procedure Codes - Situational Segment					
MC	0524	HI08-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI08-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI09-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI09-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI10-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI10-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI11-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI11-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI12-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI12-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
Loop ID 2310A - Billing Provider Information - Required Loop					
MC	0529	NM104	BILLING PROVIDER FIRST NAME	Required when NM102 = 1 (person) and the person has a first name.	Required when NM102 = 1 (person) and the person has a first name.
MC	0569	N404	BILLING PROVIDER COUNTRY CODE	Required when provider address is outside the US.	Required when provider address is outside the US.
MC	0630	REF02	BILLING PROVIDER STATE LICENSE NUMBER	Required when the billing provider does not have a National Provider ID. Use "99999" if the billing provider's type is not licensed by the state (e.g., ambulance or, durable medical equipment).	Required when DN0634 Billing Provider National Provider ID (NM109) is not reported and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0630 is known.

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2310B - Rendering Bill Provider Information - Situational Loop					
MC	0639	NM104	RENDERING BILL PROVIDER FIRST NAME	Required when NM102 = 1 (person) and the person has a first name.	Required when NM102 = 1 (person) and the person has a first name.
MC	0647	NM109	RENDERING BILL PROVIDER NATIONAL PROVIDER ID	Required when the rendering bill provider has a National Provider ID.	Required when the rendering bill provider has a National Provider ID.
MC	0651	PRV03	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	Required when the rendering bill provider does not have a National Provider ID.	Required when loop 2310B is used and DN0647 Rendering Bill Provider National Provider ID (NM109) is not reported.
MC	0643	REF02	RENDERING BILL PROVIDER STATE LICENSE NUMBER	Required when the rendering bill provider does not have a National Provider ID. Use "99999" if the billing provider's type is not licensed by the state (e.g., ambulance or, durable medical equipment).	Required when loop 2310B is used and DN0647 Rendering Bill Provider National Provider ID (NM109) is not reported.
Loop ID 2310D - Service Facility Location Information - Situational Loop					
MC	0678	NM103	FACILITY NAME	Required when service was performed at an address different from the billing provider's address and either 1) the bill was paid; or 2) the facility name is known.	Required when service was performed at an address different from DN0538 Billing Provider Primary Address and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0678 is known.
MC	0682	NM109	FACILITY NATIONAL PROVIDER ID	Required when service was performed in a facility within the US.	Required when DN0678 Facility Name is present and DN0689 Facility Country Code is not reported, or has a value of US or USA.
MC	0684	N301	FACILITY PRIMARY ADDRESS	Required when service was performed in a facility, (e.g., hospital, ambulatory surgical center, etc.).	Required when DN0678 Facility Name is present.
MC	0686	N401	FACILITY CITY	Required when service was performed in a facility, (e.g., hospital, ambulatory surgical center, etc.).	Required when DN0678 Facility Name is present.
MC	0689	N404	FACILITY COUNTRY CODE	Required when service was performed in a facility outside the US.	Required when DN0678 Facility Name is present and DN0682 Facility National Provider ID is not present.

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2310E - Referring Provider Information - Situational Loop					
MC	0691	NM104	REFERRING PROVIDER FIRST NAME	Required when NM102 = 1 (person) and the person has a first name.	Required when NM102 = 1 (person) and the person has a first name.
MC	0699	NM109	REFERRING PROVIDER NATIONAL PROVIDER ID	Required when the referring provider has a National Provider ID.	Required when the referring provider has a National Provider ID.
MC	0695	REF02	REFERRING PROVIDER STATE LICENSE NUMBER	Required when the referring provider does not have a National Provider ID. Use "99999" if the referring provider's type is not licensed by the state (e.g., ambulance or, durable medical equipment).	Required when DN0699 Referring Provider National Provider ID (NM109) is not reported.
Loop ID 2310F - Managed Care Organization Information - Situational Loop					
MC	0209	NM103	MANAGED CARE ORGANIZATION NAME	Required when service was provided under the direction or control of a managed care organization.	Required when service was provided under the direction or control of a managed care organization.
MC	0208	NM109	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	Required when DN507 Provider Agreement Code equals 'P' and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0208 is known.	Required when DN507 Provider Agreement Code equals 'P' and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0208 is known.
Loop ID 2320 - Bill Level Adjustments and Amounts - Situational Loop					
MC	0543	CAS01	BILL ADJUSTMENT GROUP CODE	Required when adjustments apply to all service lines on a medical bill containing more than one line.	Required when DN0501 Total Charge Per Bill is not equal to DN0516 Total Amount Paid Per Bill and DN0501 Total Charge Per Bill minus DN0516 Total Amount Paid Per Bill minus the sum of all DN0733 Service Adjustment Amount values is not equal to zero.
MC	0544	CAS02	BILL ADJUSTMENT REASON CODE	Required when adjustments apply to all service lines on a medical bill containing more than one line.	Required when DN0543 Bill Adjustment Group Code is present.
MC	0545	CAS03	BILL ADJUSTMENT AMOUNT	Required when adjustments apply to all service lines on a medical bill containing more than one line.	Required when DN0544 Bill Adjustment Reason Code in CAS02 is present.
MC	0545	CAS06	BILL ADJUSTMENT AMOUNT	Required when a second Bill Adjustment Reason Code applies and is associated with the same group code.	Required when DN0544 Bill Adjustment Reason Code in CAS05 is present.

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2320 - Bill Level Adjustments and Amounts - Situational Loop					
MC	0545	CAS09	BILL ADJUSTMENT AMOUNT	Required when a third Bill Adjustment Reason Code applies and is associated with the same group code.	Required when DN0544 Bill Adjustment Reason Code in CAS08 is present.
Loop ID 2400 - Service Line Information - Situational Loop					
MC	0714	SV101-2	HCPCS LINE PROCEDURE BILLED CODE	Required when the bill type is non-pharmaceutical and the service is not billed as any of the following: Oregon-specific service, pharmaceutical product, ADA procedure. The value must be valid when the service was paid using the same code that was billed.	Required when DN0715 Jurisdiction Procedure Billed Code, DN0721 NDC Billed Code, and DN0719 ADA Procedure Billed Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0715	SV101-2	JURISDICTION PROCEDURE BILLED CODE	Required when the bill type is non-pharmaceutical and the service is not billed as any of the following: HCPCS service, pharmaceutical product, ADA procedure. The value must be valid when the service was paid using the same code that was billed.	Required when DN0714 HCPCS Line Procedure Billed Code, DN0721 NDC Billed Code, and DN0719 ADA Procedure Billed Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0721	SV101-2	NDC BILLED CODE	Required when a drug is dispensed by a physician during an office visit. The value must be valid when the service was paid using the same code that was billed.	Required when DN0714 HCPCS Line Procedure Billed Code, DN0715 Jurisdictional Procedure billed Code, and DN0719 ADA Procedure Billed Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 Total Amount Paid Per Line is greater than 0 or DN0574 is not reported.
MC	0557	SV107-1	DIAGNOSIS POINTER	Required when there is a reported diagnosis code and the payment for the service line is greater than 0.	Required when DN0521 Principal Diagnosis Code is reported and either DN0574 Total Amount Paid Per Line is greater than 0 or DN0574 is not reported.

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2400 - Service Line Information - Situational Loop					
MC	0557	SV107-2	DIAGNOSIS POINTER	Required when SV107-1 is required and there are two diagnosis pointers for this service line on the bill.	Required when SV107-1 is reported and the value of the second diagnosis pointer is known.
MC	0557	SV107-3	DIAGNOSIS POINTER	Required when SV107-2 is required and there are three diagnosis pointers for this service line on the bill.	Required when SV107-2 is reported and the value of the third diagnosis pointer is known.
MC	0557	SV107-4	DIAGNOSIS POINTER	Required when SV107-3 is required and there are four diagnosis pointers for this service line on the bill.	Required when SV107-3 is reported and the value of the fourth diagnosis pointer is known.
MC	0742	SV121	PROVIDER AGREEMENT LINE CODE	Required when the provider agreement code at the line level is different than the bill level.	Required when the provider agreement code at the line level is different than the bill level.
MC	0714	SV202-2	HCPCS LINE PROCEDURE BILLED CODE	Required when a HCPCS code is used to bill for the service. The value must be valid when the service was paid using the same code that was billed.	The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0625	SV202-2	HIPPS RATE CODE	Required when a HIPPS rate code is used to bill for the service.The value must be valid when the service was paid using the same code that was billed.	The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0715	SV202-2	JURISDICTION PROCEDURE BILLED CODE	Required when an Oregon specific code is used to bill for the service.The value must be valid when the service was paid using the same code that was billed.	The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0719	SV301-2	ADA PROCEDURE BILLED CODE	Required when some amount of the bill is paid, the bill type is dental and the service is not billed as an HCPCS service. The value must be valid when the service was paid using the same code that was billed.	Required when DN0714 HCPCS Line Procedure Billed Code is not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2400 - Service Line Information - Situational Loop					
MC	0714	SV301-2	HCPCS LINE PROCEDURE BILLED CODE	Required when the bill type is dental and the service is not billed as an ADA service. The value must be valid when the service was paid using the same code that was billed.	Required when DN0719 ADA Procedure Billed Code is not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0742	SV309	PROVIDER AGREEMENT LINE CODE	Required when the provider agreement code at the line level is different than the bill level.	Required when the provider agreement code at the line level is different than the bill level.
MC	0741	CN101	CONTRACT LINE TYPE CODE	Required when a contract exists between the payer and the health care provider and the information at the line level is different than the information at the bill level.	Required when a contract exists between the payer and the health care provider and the information at the line level is different than the information at the bill level.
MC	0627	AMT02	LINE ITEM TAX CHARGE AMOUNT	Required when part of the amount charged for this service line includes a tax and the amount of tax is specified on the bill.	Required when part of either DN0552 Total Charge per Line or DN0572 Drugs/Supplies Billed Amount includes a tax and the amount of tax is specified on the bill.
Loop ID 2420 - Rendering Line Provider Information - Situational Loop					
MC	0587	NM104	RENDERING LINE PROVIDER FIRST NAME	Required when NM102 = 1 (person) and reported on the medical bill.	Required when NM102 = 1 (person) and reported on the medical bill.
MC	0592	NM109	RENDERING LINE PROVIDER NATIONAL PROVIDER ID	Required when the rendering line provider has a National Provider ID.	Required when the rendering line provider has a National Provider ID.
MC	0595	PRV03	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	Required when the rendering line provider does not have a National Provider ID.	Required when NM109 DN0592 Rendering Line Provider National Provider ID is not present.
MC	0599	REF02	RENDERING LINE PROVIDER STATE LICENSE NUMBER	Required when the rendering line provider does not have a National Provider ID. Use "99999" if the billing provider's type is not licensed by the state (e.g., ambulance or interpreter).	Required when NM109 DN0592 Rendering Line Provider National Provider ID is not present.

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop					
MC	0574	SVD02	TOTAL AMOUNT PAID PER LINE	Required when the amount paid for this service line is not equal to the amount charged.	Required when the amount paid is not equal to which of the following data elements is reported: DN0552 Total Charge per Line or DN0572 Drugs/Supplies Billed Amount.
MC	0722	SVD03-2	ADA PROCEDURE PAID CODE	Required when the service was paid more than $0.00 using a different code from the billed code and no other paid service code was used.	Required when • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.
MC	0726	SVD03-2	HCPCS LINE PROCEDURE PAID CODE	Required when the service was paid more than $0.00 using a different code from the billed code and no other paid service code was used.	Required when • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.
MC	0728	SVD03-2	NDC PAID CODE	Required when the service was paid more than $0.00 using a different code from the billed code and no other paid service code was used.	Required when • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop					
MC	0729	SVD03-2	JURISDICTION PROCEDURE PAID CODE	Required when the service was paid more than $0.00 using a different code from the billed code and no other paid service code was used.	Required when • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.
MC	0547	SVD06	LINE NUMBER	Required when the payment is bundled with a different service line.	Required when the payment is bundled with a different service line.
MC	0731	CAS01	SERVICE ADJUSTMENT GROUP CODE	Required when line-level adjustments were applied during the adjudication of the medical bill.	For non-pharmaceutical bills (SV4 segment is not used to report the service line), this element is required when DN0545 Bill Adjustment Amount is not reported and DN0552 Total Charge Per Line does not equal DN0574 Total Amount Paid Per Line.For pharmaceutical bills (SV4 segment is used to report the service line), this element is required when DN0545 is not reported and DN0572 Drugs/Supplies Billed Amount does not equal DN0574.
MC	0732	CAS02	SERVICE ADJUSTMENT REASON CODE	Required when line level adjustments were applied during the adjudication of the medical bill.	Required when DN0543 Bill Adjustment Group Code is present.
MC	0733	CAS03	SERVICE ADJUSTMENT AMOUNT	Required when line level adjustments were applied during the adjudication of the medical bill.	Required when DN0544 Bill Adjustment Reason Code in CAS02 is present.
MC	0733	CAS06	SERVICE ADJUSTMENT AMOUNT	Required when it is necessary to report another adjustment beyond what has already been reported for this service line.	Required when DN0544 Bill Adjustment Reason Code in CAS05 is present.

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop					
MC	0733	CAS09	SERVICE ADJUSTMENT AMOUNT	Required when it is necessary to report another adjustment beyond what has already been reported for this service line.	Required when DN0544 Bill Adjustment Reason Code in CAS08 is present.
MC	0733	CAS12	SERVICE ADJUSTMENT AMOUNT	Required when it is necessary to report another adjustment beyond what has already been reported for this service line.	Required when DN0544 Bill Adjustment Reason Code in CAS11 is present.
MC	0733	CAS15	SERVICE ADJUSTMENT AMOUNT	Required when it is necessary to report another adjustment beyond what has already been reported for this service line.	Required when DN0544 Bill Adjustment Reason Code in CAS14 is present.
MC	0628	AMT02	LINE ITEM TAX PAID AMOUNT	Required when part of the amount paid for this service line includes a billed tax.	Required when DN0574 Total Amount Paid Per Line is present and DN0627 Line Item Tax Charge Amount is present.

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 162

ELECTRONIC DATA INTERCHANGE; PROOF OF COVERAGE

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436-162-0001 Authority for Rules

(1) These rules are promulgated under the director's authority contained in ORS 656.726(4).

(2)(a) These rules apply to workers' compensation proof of coverage transactions filed with the director by electronic data interchange (EDI) on or after April 1, 2015.

(b) For coverage effective before July 1, 2009, the insurer must contact the director if the insurer is unable to file proof of coverage by EDI.

(3) The director's purpose is to require workers' compensation proof of coverage reporting by EDI.

(4) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(5) Orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 are considered orders of the director.

Stat. Auth.: ORS 656.264 and 656.726(4)
Stats. Implemented: ORS ch. 84, 656.017, 656.407, 656.419, 656.423, and 656.427
Hist.: Amended 11/13/14 as Admin. Order14-061, eff. 4/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-162-0004 Adoption of Standards

(1) The director adopts, by reference, IAIABC EDI Implementation Guide for Proof of Coverage, Release 2.1, dated July 1, 2010.

(2) The form, format, and delivery of data elements reported and definitions will conform to these standards, unless otherwise provided in these rules.

(3) A copy of the Release 2.1 guide is available for review during regular business hours at the Workers' Compensation Division, Operations Section, 350 Winter Street NE, Salem OR 97301, 503-947-7742. IAIABC members may view a copy of the Release 2.1 guide, or non-members may purchase a copy, at the IAIABC website: http://www.iaiabc.org.

Stat. Auth.: ORS 656.264
Stats. Implemented: ORS 656.017, 656.407, 656.419, 656.423, and 656.427
Hist.: Amended 11/13/14 as Admin. Order14-061, eff. 4/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-162-0005 General Definitions

For the purpose of these rules:

(1) "Director" means the director of the Department of Consumer and Business Services or the director's designee for the matter.

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

(3) "Electronic data interchange" or "EDI" means a computer to computer exchange of information in a standardized electronic format.

(4) "Electronic record" means information created, generated, sent, communicated, received, or stored by electronic means.

(5) "Establishing document" means a transaction that reports coverage for one or more entities. Establishing document types are coverage notice/binders, new policies, rewrite/reissue transactions, renewals, reinstatements, add jurisdiction endorsements, or add employer/location endorsements.

(6) "Exclude (X)" means the data element must not be sent or cannot be sent.

(7) "Expected (E)" means the data element is expected on the transaction, but the transaction will be accepted with errors should it fail any edit.

(8) "Fatal Technical (F)" means the data element must be sent.

(9) "Fatal Technical/Conditional (FT)" means the data element must be sent when certain conditions are present.

(10) "FEIN" means the federal employer identification number or other federal reporting number used by the Internal Revenue Service (IRS) to identify a business entity and by the insurer, insured, or employer for federal tax reporting purposes.

(11) "Header record" means the record that precedes each transmission for the purpose of identifying a sender, the date and time of the transmission, and the transaction set within the transmission.

(12) "IAIABC" means the International Association of Industrial Accident Boards and Commissions, a professional trade association consisting of state workers' compensation regulators and insurance and corporate agency representatives (www.iaiabc.org).

(13) "If Applicable/Available with Item Accept if Invalid (IA)" means the data may or may not be populated. If present, may be edited for valid value or format. The division may or may not return an error on validity edits.

(14) "Industry code" means the code that indicates the nature of the employer's business as published in the North American Industrial Classification System (NAICS) manual, available in print and on CD-ROM from the National Technical Information Service (NTIS) http://www.ntis.gov/products/naics.aspx. NAICS codes may also be viewed at the U.S. Census Bureau webpage (http://www.census.gov/eos/www/naics/).

(15) "Information" means data, text, images, sounds, codes, computer programs, software, databases, or the like.

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

(17) "Mandatory (M)" means the data element must be sent. If the data element is omitted or submitted in a format the division is unable to process, the transaction will be rejected.

(18) "Mandatory/Conditional (MC)" means the data element must be sent when certain conditions are present.

(19) "Not Applicable (NA)" means the data element is not required to be sent, but it may be sent. If it is sent, edits may be applied, but unsuccessful edits will not cause the transaction to be rejected.

(20) "Proof of coverage" means an electronic record or set of records identifying an insurer as providing workers' compensation coverage for a specific employer.

(21) "Record" means electronic record.

(22) "Restricted (R)" means the data element value will not be accepted if a stated condition exists.

(23) "Sender" means the vendor or insurer authorized to send EDI transactions to the division.

(24) "Trailer record" means the record that designates the end of a transmission and provides a count of transactions contained within the transmission, not including the header and trailer records.

(25) "Transaction" means a set of EDI records, defined according to standards in OAR 436-162-0004(1).

(26) "Transaction reason code" means the two-digit code identifying the type of transaction and why it was sent (e.g., 54, adding an employer location).

(27) "Transaction set purpose code" means the code identifying whether the transaction is an original, change, or replacement transaction (e.g., 00, original).

(28) "Transaction set type code" means the code identifying the purpose of individual records within the transaction (e.g., 42, canceled by insured).

(29) "Transmission" means a defined set of transactions, including both header and trailer records sent to the division or sender by EDI.

(30) "Triplicate code" means the series of three two-digit codes that define the specific purpose of individual records in a proof of coverage transmission in this order: transaction set purpose code, transaction set type code, and transaction reason code.

(31) "Vendor" means an agent identified by an insurer to submit transmissions to the division on behalf of the insurer.

Stat. Auth.: ORS 656.264 and 656.726(4)
Stats. Implemented: ORS 84.004 and 656.264
Hist.: Amended 11/13/14 as Admin. Order14-061, eff. 4/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-162-0030 Retention of Electronic Records

Insurers and self-insured employers must retain workers' compensation records under OAR 436-050-0120 and OAR 436-050-0220. Records may be retained in electronic format if the records can be reproduced.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.455 and 731.475
Hist.: Adopted 10/1/10 as Admin. Order 10-058, eff. 1/1/11

436-162-0035 General Filing Information

(1) Senders must follow United States Postal Service guidelines for reporting all addresses.

(2) Transactions will be rejected if Mandatory or Mandatory/Conditional data elements are omitted or submitted in a form or format the division is unable to process.

(3) Not Applicable data element(s) in a transaction will be ignored if the data element is either omitted or submitted in a form or format the division is unable to process.

(4) Worker leasing company (also known in other jurisdictions as professional employer organization) policies will be accepted by EDI, subject to the same data and transaction editing standards as other policies. A policy filing for a worker leasing company does not eliminate the worker leasing company's requirement to file worker leasing notices under OAR 436-050-0410.

(5) Wrap-up policies will be accepted by EDI, subject to the same data and transaction editing standards as other policies. Wrap-up projects and any change of insurer mid-project must be approved by the Oregon Insurance Division.

Stat. Authority: ORS 656.264, 656.419, 656.423, 656.427, 656.726(4)
Stat. Implemented: ORS 656.419, 656.423, 656.427
Hist: Adopted 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0038 Acknowledgement

(1) The division will respond to submitted transmissions by providing either a Transaction Accepted (TA) or a Transaction Rejected (TR) acknowledgement.

(2) Transaction rejected acknowledgements will be generated for transactions with errors, including but not limited to:

(a) An omitted Mandatory data element;

(b) An improperly populated data element field, e.g., numeric data element field is populated with alpha or alphanumeric data, or is not a valid value;

(c) Transactions or electronic records within the transaction that require matching and cannot be matched to the division's database;

(d) Illogical data in a Mandatory or Mandatory/Conditional field, e.g., policy expiration date is before policy effective date;

(e) Duplicate transmission or duplicate transaction within the transmission;

(f) Invalid triplicate code; or

(g) Illogical event sequence relationship between transactions, e.g., endorsement transaction submitted before a policy transaction is submitted.

(3) The insurer must correct and resubmit any transactions rejected for which a law or rule requires reporting to the director.

(4) Transactions that are not rejected under section (2) of this rule will result in a Transaction Accepted acknowledgement.

(5) An insurer's obligation to file proof of coverage for the purposes of this rule is not satisfied unless the director acknowledges acceptance of the transaction.

Stat. Authority: ORS 656.264, 656.419, 656.423, 656.427, 656.726(4)
Stat. Implemented: ORS, 656.419, 656.423, 656.427
Hist: Amended and renumbered from 436-162-0320 11/13/14 as Admin. Order14-061, eff. 4/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-162-0040 Recognized Filing Date

(1) An electronic record is considered filed on the date it is delivered to the director only if the division issues a Transaction Accepted acknowledgment.

(2) Rejected transactions are not considered filed and do not satisfy proof of coverage requirements until they are corrected, resubmitted, and accepted by the division.

Stat. Auth.: ORS 656.264 and 656.726(4)
Stats. Implemented: ORS 84.043 and 656.264
Hist.: Amended 11/13/14 as Admin. Order14-061, eff. 4/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-162-0310 Electronic Filing Requirements

(1) Unless otherwise provided in these rules, insurers must transmit proof of coverage by EDI, and either use an approved vendor, or be approved as a sender.

(2) Unless otherwise provided in these rules, the data elements have the meaning provided in the data dictionary of the IAIABC EDI Implementation Guide for Proof of Coverage, Release 2.1, dated July 1, 2010, referenced in OAR 436-162-0004(1).

(3) Data elements are listed in Appendices A and B:

(a) Appendix A shows all proof of coverage data elements accepted by EDI in Oregon, and whether the data element is Exclude (X), Expected (E), Fatal Technical (F), Fatal Technical/Conditional (FT), Mandatory (M), Mandatory/Conditional (MC), Not Applicable (NA), or Restricted (R), for each transaction type.

(b) Appendix B lists Mandatory/Conditional data elements and the applicable conditions that make the data element mandatory.

(4) Filing due dates are listed in Appendix C, the Event Table.

(5) An insurer may file proof of coverage EDI by:

(a) Transmitting an electronic record of the proof of coverage data elements identified as Mandatory or Mandatory/Conditional, including a correct FEIN, as defined in OAR 436-162-0005(10), for each legally distinct employer included in the establishing document transaction; and

(b) Transmitting an establishing document transaction, coverage notice/binder, new/renew policy, rewrite/reissue policy, reinstatement, add location, add employer, or add jurisdiction.

(6) If an employer elects to include any nonsubject worker(s) for coverage, or subsequently to exclude such workers from coverage, the insurer must submit a transaction with a reason code for including or excluding a corporate officer, partner, member, sole proprietor, or any other nonsubject worker as described in ORS 656.027.

(7) Insurers may not:

(a) Submit placeholder or invalid FEINs; or

(b) Submit paper documents to the director without the director's express permission.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.264
Hist.: Amended 11/13/14 as Admin. Order14-061, eff. 4/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-162-0335 Testing Procedures and Transaction Accuracy Standards

(1) An insurer that wants to self report proof of coverage must report through an approved vendor until the insurer completes all of the testing requirements in this rule and receives approval from the director to self report.

(2) To obtain approval, each sender must successfully complete the Secure File Transfer Protocol (SFTP) test, demonstrate ability to successfully transmit coverage data in the format specified in OAR 436-162-0004(1), achieve ninety percent reporting accuracy, and retrieve and process automated EDI acknowledgements.

(3) To begin the testing process for proof of coverage EDI, the sender must:

(a) Contact the division's EDI coordinator. Contact information is on the division's webpage: http://wcd.oregon.gov/insurer/edi/Pages/proof-of-coverage.aspx; and

(b) Complete and submit the proof of coverage EDI transmission profile (Form 440-4979), available from: http://wcd.oregon.gov/insurer/edi/Pages/proof-of-coverage.aspx.

(4) A successful EDI test is determined by the following:

(a) The resolution of any consistently recurring Fatal Technical errors identified by the division;

(b) Transmissions are sent to the division without errors in the header or trailer record;

(c) Transmissions are sent to the division without transaction level technical errors; and

(d) The sender is able to retrieve and process the automated EDI acknowledgement transactions.

(5) To move from testing to production:

(a) The sender must submit a minimum of three transmissions containing at least three records for each Oregon valid triplicate code included in Appendix A.

(b) Data transmitted during the proof of coverage EDI test must represent actual proof of coverage data, which will be discarded after the test.

(c) The division will provide the sender with an acknowledgement file to account for the processing outcome of each transaction, i.e., accepted or rejected. The sender should reconcile or correct identified data errors in their source data system as necessary.

(d) Ninety percent of transactions submitted during the testing phase must be accepted by the division. Additional proof of coverage EDI test transmission(s) may be required until a ninety percent accuracy rate is achieved.

(6) The director will notify senders once they have successfully completed testing.

(7) Once approved, the sender must maintain the accuracy as defined in sections (4) and (5)(d) of this rule. Failure to meet technical requirements may result in the revocation of EDI transmission approval.

(8) The division will inform the sender and insurer (if different) if accuracy standards for technical requirements fall below standards prescribed in sections (2) and (5)(d) of this rule.

Stat. Authority: ORS 656.264, 656.419, 656.423, 656.427, 656.726(4)
Stat. Implemented: ORS 656.264, 656.419, 656.423, 656.427
Hist: Amended and renumbered from 436-162-0060 11/13/14 as Admin. Order14-061, eff. 4/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-162-0340 Changes or Corrections

(1) Changes or corrections to proof of coverage information must be submitted under the standards referenced in OAR 436-162-0004(1).

(2) To report changes or corrections of an insured employer's name or address, or other data elements, the insurer must transmit the appropriate transaction to specify what data is being changed or corrected.

(3) The insurer's policy number is used to assist in matching each transaction to the appropriate employer. When an insurer changes a policy number, the insurer must report that change prior to the next transaction submitted for that policy. Failure to report a change in the policy number will prevent future filings from being processed by the division's information processing system and the insurer will receive a Transaction Rejected acknowledgement.

(4) To add or delete coverage for corporate officers, members of a limited liability company, partners, sole proprietors, or other nonsubject workers, the insurer must file the appropriate "include" or "exclude" endorsement transaction to the associated policy filing.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.264 and 656.419
Hist.: Amended 11/13/14 as Admin. Order14-061, eff. 4/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-162-0370 Proof of Coverage Terminations

When the insurer cancels coverage before the expiration of the policy term, the insurer must:

(1) Provide written notice to the employer under ORS 656.427(1) and (3);

(2) Retain a record of the written notice sent to the employer under ORS 656.427, and proof of mailing of that notice, for inspection by the division; and

(3) Provide notice to the director under ORS 656.427 by EDI.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.264, 656.419, 656.423 and 656.427
Hist: Amended 11/13/14 as Admin. Order14-061, eff. 4/1/15
See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-162-0380 Cancellation of Coverage by the Employer

When the employer cancels coverage before the expiration of the policy term, the insurer must:

(1) Retain a record of the written or verbal notice provided by the employer to the insurer under ORS 656.423, including proof of date of receipt of that notice, for inspection by the division; and

(2) Provide notice to the director under ORS 656.423 by EDI.

Stat. Authority: ORS 656.264, 656.423, 656.726(4)
Stat. Implemented: ORS 656.423
Hist: Adopted 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0400 Monitoring and Auditing Insurers

(1) The director may monitor and conduct periodic audits of proof of coverage reporting data to ensure compliance with ORS chapter 656 and these rules. If the director finds violations of the reporting requirements of these rules the director may issue civil penalties under OAR 436-162-0440 and ORS 656.745.

(a) Proof of coverage must be reported timely. "Timely" means that an insurer reports data within the time allowed by these rules, including Appendix C, the Event Table.

(b) Proof of coverage must be reported accurately. "Accurately" means that the reported coverage data accepted by the division conforms to the reporting requirements of these rules, including Appendices A, B, and C.

(2) All records maintained or required to be maintained must be disclosed upon request by the director.

Stat. Authority: ORS 656.264, 656.726(4), 656.745
Stat. Implemented: ORS 656.419, 656.423, 656.427
Hist: Adopted 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0440 Assessment of Civil Penalties

(1) Under ORS 656.745, the director may assess a civil penalty against an insurer that fails to comply with ORS chapter 656 or the director's rules and orders.

(2) The insurer is responsible for its own actions as well as the actions of others acting on the insurer's behalf. If an insurer or someone acting on the insurer's behalf violates any provisions of these rules, the director may impose a civil penalty against the insurer.

Stat. Authority: ORS 656.264, 656.726(4), 656.745
Stat. Implemented: ORS 656.419, 656.423, 656.427
Hist: Adopted 11/13/14 as Admin. Order14-061, eff. 4/1/15

Appendix A, B, and C (OAR 436-162-0310) [link to tables]

If the above link does not connect you to the electronic data interchange webpage, please copy and paste the following link into your browser's URL window:

http://wcd.oregon.gov/insurer/edi/Pages/proof-of-coverage.aspx

OREGON ADMINISTRATIVE RULES CHAPTER 436, DIVISION 170

INDEPENDENT CONTRACTORS

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436-170-0002 Purpose of Rule

The Landscape Contractors Board, Department of Revenue, Department of Consumer and Business Services, Employment Department, and Construction Contractors Board must adopt rules together to carry out ORS 670.600. ORS 670.600 defines "independent contractor" for purposes of the programs administered by these agencies. This rule is intended to ensure that all five agencies apply and interpret ORS 670.600 in a consistent manner; to clarify the meaning of terms used in ORS 670.600; and, to the extent possible, to enable interested persons to understand how all five agencies will apply ORS 670.600.

Stat. Auth: ORS 656.726(4); 670.605
Stats. Implemented: ORS 316.162; 670.600
Hist.: Adopted 1/30/07 as WCD Admin. Order 07-050, eff. 2/1/07

436-170-0100 Statutory Context

(1) ORS 670.600 generally establishes three requirements for "independent contractors." One requirement is that an "independent contractor" must be engaged in an "independently established business." Another requirement is related to licenses and certificates that are required for an "independent contractor" to provide services. A third requirement is that an "independent contractor" must be "free from direction and control over the means and manner" of providing services to others.

(2) The specific focus of this rule is the "direction and control" requirement. See ORS 670.600 for the requirements of the "independently established business" test and for licensing and certification requirements.

Stat. Auth: ORS 656.726(4); 670.605
Stats. Implemented: ORS 316.162; 670.600
Hist.: Adopted 1/30/07 as WCD Admin. Order 07-050, eff. 2/1/07

436-170-0200 Direction and Control Test

(1) ORS 670.600 states that an "independent contractor" must be "free from direction and control over the means and manner" of providing services to others. The agencies that have adopted this rule will use the following definitions in their interpretation and application of the "direction and control" test:

(a) "Means" are resources used or needed in performing services. To be free from direction and control over the means of providing services an independent contractor must determine which resources to use in order to perform the work, and how to use those resources. Depending upon the nature of the business, examples of the "means" used in performing services include such things as tools or equipment, labor, devices, plans, materials, licenses, property, work location, and assets, among other things.

(b) "Manner" is the method by which services are performed. To be free from direction and control over the manner of providing services an independent contractor must determine how to perform the work. Depending upon the nature of the business, examples of the "manner" by which services are performed include such things as work schedules, and work processes and procedures, among other things.

(c) "Free from direction and control" means that the independent contractor is free from the right of another person to control the means or manner by which the independent contractor provides services. If the person for whom services are provided has the right to control the means or manner of providing the services, it does not matter whether that person actually exercises the right of control.

(2) Right to specify results to be achieved. Specifying the final desired results of the contractor's services does not constitute direction and control over the means or manner of providing those services.

Stat. Auth: ORS 656.726(4); 670.605
Stats. Implemented: ORS 316.162; 670.600
Hist.: Adopted 1/30/07 as WCD Admin. Order 07-050, eff. 2/1/07

436-170-0300 Application of "direction and control" test in construction and landscape industries

(1) The provisions of this section apply to:

(a) Architects licensed under ORS 671.010 to 671.220;

(b) Landscape architects licensed under ORS 671.310 to 671.479;

(c) Landscaping businesses licensed under ORS 671.510 to 671.710;

(d) Engineers licensed under ORS 672.002 to 672.325; and

(e) Construction contractors licensed under ORS chapter 701.

(2) A licensee described in section (1) that is paying for the services of a subcontractor in connection with a construction or landscape project, will not be considered to be exercising direction or control over the means or manner by which the subcontractor is performing work when the following circumstances apply:

(a) The licensee specifies the desired results of the subcontractor's services by providing plans, drawings, or specifications that are necessary for the project to be completed.

(b) The licensee specifies the desired results of the subcontractor's services by specifying the materials, appliances or plants by type, size, color, quality, manufacturer, grower, or price, which materials, appliances or plants are necessary for the project to be completed.

(c) When specified by the licensee's customer or in a general contract, plans, or drawings and in order to specify the desired results of the subcontractor's services, the licensee provides materials, appliances, or plants, including, but not limited to, roofing materials, framing materials, finishing materials, stoves, ovens, refrigerators, dishwashers, air conditioning units, heating units, sod and seed for lawns, shrubs, vines, trees, or nursery stock, which are to be installed by subcontractors in the performance of their work, and which are necessary for the project to be completed.

(d) The licensee provides, but does not require the use of, equipment (such as scaffolding or fork lifts) at the job site, which equipment is available for use on that job site only, by all or a significant number of subcontractors requiring such equipment.

(e) The licensee has the right to determine, or does determine, in what sequence subcontractors will work on a project, the total amount of time available for performing the work, or the start or end dates for subcontractors working on a project.

(f) The licensee reserves the right to change, or does change, in what sequence subcontractors will work on a project, the total amount of time available for performing the work, or the start or end dates for subcontractors working on a project.

Stat. Auth: ORS 656.726(4); 670.605
Stats. Implemented: ORS 316.162; 670.600
Hist.: Adopted 1/30/07 as WCD Admin. Order 07-050, eff. 2/1/07

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Key:

CDA = claim disposition agreement
MCO = managed care organization
PPD = permanent partial disability
PTD = permanent total disability
IME = independent medical examination
WBF = workers' benefit fund
NCE = non-complying employer
EDI = electronic data interchange

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