

# Agenda

## Rulemaking Advisory Committee

Workers' Compensation Division Rules  
OAR chapter 436, divisions 030 and 060, etc.

<b>Type of meeting:</b>	Rulemaking advisory committee
<b>Date, time, &amp; place:</b>	July 14, 2015, 2:00 to 4:30 p.m.  Room B, Labor and Industries Building, Salem, Oregon  Dial-in information: 213-787-0529   Access code: 9221262#
<b>Facilitator:</b>	Fred Bruyns, Workers' Compensation Division
<b>2:00 to 2:10</b>	Welcome and introductions; meeting objectives
<b>2:10 to 4:20</b>	Discussion of issues on file  Request for new issues related to implementation of SB 371, HB 2211, HB 2797, and HB 2478
<b>4:20 to 4:30</b>	Summing up – next steps – thank you!

- [Issues document for OAR 436-030, Claim Closure and Reconsideration](#) (attached)
- [Issues document for OAR 436-060, Claims Administration](#) (attached)
- [Issues document for OAR 436-075, Retroactive Program](#) (attached)
- [Issues document for OAR 436-100, Workers' Compensation Benefits Offset](#) (attached)
- [Extracts from division 030 \(temporary rule\) and division 060](#) (attached)
- [Notice of Closure, Form 1644 | Notice of Closure - Permanent Total Disability Reduction, Form 1644p](#) (attached)
- [Request for Reconsideration Form 2223a | Form 2223b](#) (attached)

See links to additional documents on next page.

## Links to related documents:

- Enrolled Senate Bill 371:  
<https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB371/Enrolled>
- Enrolled HB 2211:  
<https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/HB2211/Enrolled>
- Enrolled HB 2478:  
<https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/HB2478/Enrolled>
- Enrolled HB 2797:  
<https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/HB2797/Enrolled>
- OAR 436-030 temporary rules, effective 5/21/15:  
[http://www.cbs.state.or.us/wcd/policy/rules/docconv\\_21365/30\\_15059ub.pdf](http://www.cbs.state.or.us/wcd/policy/rules/docconv_21365/30_15059ub.pdf)
- OAR 436-060 permanent rules, effective 4/1/11:  
[http://www.cbs.state.or.us/wcd/policy/rules/docconv\\_21365/60\\_11052.pdf](http://www.cbs.state.or.us/wcd/policy/rules/docconv_21365/60_11052.pdf)
- Bulletin 139, effective 5/21/15:  
[http://www.cbs.state.or.us/wcd/policy/bulletins/docconv\\_12819/bul\\_139.pdf](http://www.cbs.state.or.us/wcd/policy/bulletins/docconv_12819/bul_139.pdf)
- Forms 1644, 1644c, 1644r, 1644p:  
<http://www.cbs.state.or.us/wcd/policy/bulletins/formsbyno.html>
- Bulletin 227: [http://www.cbs.state.or.us/wcd/policy/bulletins/docconv\\_12819/bul\\_227.pdf](http://www.cbs.state.or.us/wcd/policy/bulletins/docconv_12819/bul_227.pdf)
- Forms 2223a, 2223b: <http://www.cbs.state.or.us/wcd/policy/bulletins/formsbyno.html>
- SAIF v. Wild: <http://www.publications.ojd.state.or.us/docs/A137352.htm>
- Sather v. SAIF: <http://www.publications.ojd.state.or.us/docs/S062466.pdf>
- Liberty Northwest v. Olvera-Chavez: <http://www.publications.ojd.state.or.us/docs/A152550.pdf>

# OAR 436-030, Claim Closure and Reconsideration Issues Document

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Senate Bill 371, relating to notice of closure of workers' compensation claims, became effective May 21, 2015. The division adopted temporary rules to implement SB 371 effective May 21, 2015; permanent rules need to be adopted no later than November 16, 2015.

## **ISSUE #1 – Beneficiaries' rights**

**Issue:** Under SB 371, a beneficiary may request reconsideration in a claim in which the worker dies before final determination of issues in the claim. What about a fatal claim, in which the worker dies as a result of the injury? The issues raised by a beneficiary's request for reconsideration and the scope of ARU's review may be different depending on the type of claim.

**Background:** SB 371 provides beneficiaries with the right to: (1) request reconsideration of a notice of closure issued after the worker has died, (2) file a request for reconsideration after the worker has died, and (3) pursue a request for reconsideration filed by the worker before the worker died.

There are two types of claims in which a beneficiary may be a party:

- 1) Death benefits under ORS 656.204 if the worker died as a result of a compensable injury (or under ORS 656.208 if the worker died while PTD).
- 2) Survivor benefits under ORS 656.218 if a worker with a compensable injury later died for reasons unrelated to the injury. In that case any compensation the worker would have been entitled to is paid to the worker's beneficiaries or estate.

The case that SB 371 was intended to address, *SAIF v. Wild*, 237 Or App 454 (2010), was a case in which the worker filed a claim and then died while the denial of his claim was in litigation. After the worker died, the denial was set aside, the claim was accepted and closed, and the worker's attorney filed a request for reconsideration. The issue addressed by the court was whether the worker's minor daughter had to request reconsideration to pursue the benefits the worker would have been entitled to, under ORS 656.218.

In the case of a worker who dies for reasons unrelated to the injury, the closure and reconsideration processes determine the compensation (permanent and temporary disability) the worker may have been entitled to had the worker lived.

What is the purpose of the reconsideration process in a fatal claim, when benefits are not necessarily due the worker, but death benefits may be payable to the worker's beneficiaries?

### **Alternatives:**

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**Recommendation:**

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**ISSUE #2 – SB 371, Beneficiaries**

**Rule:** 436-030-0005(9), Definitions

**Issues:** The temporary rules amended the definition of “Notice of Closure” to be notice to the worker or beneficiary. Should this rule change be adopted permanently?

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendation:**

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**ISSUE #3 – Beneficiaries**

**Rule:** 436-030-0015(1)(c)(B)(ii), Insurer Responsibility

**Issue:** Should the rules continue to require the Updated Notice of Acceptance and Closure issued in an instant fatality to list the names of all known beneficiaries? Or should the rules only require a general notice to any beneficiaries that they may be entitled to death benefits?

**Background:** Prior to SB 371, the rule has required the combined Updated Notice of Acceptance and Closure issued in an instant fatality to include the names of all known beneficiaries, the beneficiaries’ right to and the extent of fatal benefits due under ORS 656.204, and the medically stationary date.

ORS 656.268(5)(a)(C) (pre-SB 371) requires a notice of closure to inform “[a]ny beneficiaries of death benefits to which they may be entitled pursuant to ORS 646.204 and 656.208.” This

requirement could be interpreted as a more general notice requirement to any and all beneficiaries that they may be entitled to benefits. See footnote 5 in *SAIF v. Wild*, 237 Or App 454, 466 (2010):

“We recognize that ORS 656.268(5)(a)(C) requires the notice of closure to inform ‘[a]ny beneficiaries of death benefits to which they may be entitled pursuant to ORS 656.204 and 656.208.’ We do not understand that provision to require insurers to identify a deceased worker's statutory beneficiaries and to provide them with a copy of the notice. Rather, we understand it to require only that the insurer include in the notice a statement that beneficiaries may be entitled to receive statutorily authorized death benefits. SAIF complied with that requirement by including in the August 16, 2006, notice of closure the following statement: ‘The worker's beneficiaries are entitled to any unpaid compensation for temporary or permanent partial disability.’ ”

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendation:**

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**ISSUE #4 – SB 371, Beneficiaries**

**Rule:** 436-030-0015(1)(c)(B)(iii), Insurer Responsibility

**Issue:** The temporary rules require language in the combined Updated Notice of Acceptance and Closure issued in an instant fatality claim to include appeal rights of beneficiaries. Should this language be adopted permanently? Is this language necessary in an “instant fatal” claim, when there wouldn’t necessarily be any issues on which a beneficiary would challenge the closure?

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendation:**

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**ISSUE #5 – SB 371, Beneficiaries**

**Rule:** 436-030-0020, Requirements for Claim Closure

**Issue:** Regarding the Notice of Closure, the temporary rules:

- Amended section (5) to provide that the notice is effective the date it is mailed to the worker or the worker’s estate if the worker is deceased.
- Amended subsection (6)(j) to require the notice to include the appeal rights of the worker and any beneficiaries.
- Added section (9) to provide where to mail copies of the notice if the worker is deceased.
- Amended *renumbered* section (10) to require the worker’s and beneficiaries’ copies of the notice to be mailed by regular and certified mail.

Should these rule amendments be adopted permanently?

An agency committee suggested that no change be made to *renumbered* section (10), but a second sentence be added to *temporary* section (9), subsection (b), providing that if copies of the Notice of Closure are mailed to beneficiaries, they must be mailed by both regular mail and certified mail return receipt requested.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendation:**

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**ISSUE #6 – SB 371, Beneficiaries**

**Forms:**

- 1644, Notice of Closure
- 1644c, Correcting Notice of Closure
- 1644r, Rescinding Notice of Closure
- 1644p, Notice of Closure-Permanent Total Disability Reduction
- Bulletin 139, Claim closure

**Issue:** Effective May 21, 2015, the division revised the notice of closure forms 1644, 1644c, and 1644r, and accompanying Bulletin 139, “Claim closure,” to include a “Notice to Beneficiaries” and add a cc: box for beneficiaries. Should further changes be made to these forms or the bulletin?

The division has not revised the 1644p, “Notice of Closure-Permanent Total Disability Reduction,” to include the same language that was added to the other closure forms. Should the language also be added to this form? The appeal rights for a notice of closure that reduces PTD are under ORS 656.206(6)(a): “Notwithstanding ORS 656.268 (5), if a worker objects to a notice of closure issued under this subsection, the worker must request a hearing.”

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendation:**

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**ISSUE #7 – SB 371, Beneficiaries**

**Rule:** 436-030-0023, Correcting and Rescinding Notices of Closure

**Issue:** The temporary rules amended sections (6), (7), and (9) of this rule to reference *temporary* OAR 436-030-0145(1) for the applicable appeal period that is initiated when a rescinding notice of closure, a notice of closure that rescinds and reissues the closure, or a correcting notice of closure is issued. (*Temporary* OAR 436-030-0145(1), in turn, adds language providing the time period during which a beneficiary may request reconsideration (see issue #10 below).) Should these rule changes be adopted permanently?

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendation:**

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**ISSUE #8 – SB 371, Beneficiaries**

**Rules/forms/bulletin:**

436-030-0115, Reconsideration of Notices of Closure  
436-030-0125, Reconsideration Form and Format  
Form 2223a, Worker Request for Reconsideration  
Form 2223b, Insurer Request for Reconsideration  
Bulletin 227, Request for reconsideration forms

**Issue/Background:** In the temporary rules, the division amended 436-030-0115(1) to include a beneficiary as a party that may request reconsideration of a notice of closure, and 436-030-0125(7) to provide that a request made by a beneficiary should include the beneficiary's and attorney's names.

- Is there any other information or documentation that a beneficiary should include with their request?
- Is the current form for worker requests sufficient for a beneficiary's request, or should a new form be created for beneficiaries to request reconsideration?
- The division has not made any changes to the worker or insurer request forms (2223a, 2223b) or to Bulletin 227 as a result of SB 371. Do any changes need to be made to these forms and bulletin?

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendation:**

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**ISSUE #9 – SB 371, Beneficiaries**

**Rule:** 436-030-0135(1), Reconsideration Procedure

**Issue:** In the temporary rules, the division amended this rule to require the insurer to provide a copy of the record to the beneficiary or the beneficiary's attorney, if the request for reconsideration was made by the beneficiary. Should this rule change be adopted permanently?

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendation:**

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**ISSUE #10 – SB 371, Beneficiaries**

**Rule:** 436-030-0145, Reconsideration Time Frames and Postponements

**Issue:** In the temporary rules, the division amended:

- Section (1) to add the timeframes for beneficiaries to request reconsideration.
- Section (2) to provide that the reconsideration proceeding begins upon receipt of the worker's or beneficiary's request.

Should these rule changes be adopted permanently?

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendation:**

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**ISSUE #11 – *Sather v. SAIF*, worker’s estate**

**Rule:**

436-030-0115, Reconsideration of Notices of Closure  
436-030-0125, Reconsideration Form and Format  
436-030-0135, Reconsideration Procedure  
436-030-0145, Reconsideration Time Frame and Postponement  
Other rules?

**Issue/Background:** In *Sather v. SAIF*, 357 Or 122 (2015), the Oregon Supreme Court interpreted ORS 656.218(3) to allow a deceased worker’s estate to pursue litigation initiated by the worker if the worker does not have statutory beneficiaries. SB 371 amended ORS 656.218(3) and (4) to include a request for reconsideration, in addition to a request for hearing, as a matter that the worker’s beneficiaries may file and pursue if the worker dies before final determination.

In light of *Sather v. SAIF* and the changes to ORS 656.218(4) by SB 371, should the rules be amended reflect the right of the worker’s estate to request and pursue reconsideration in the absence of beneficiaries?

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendation:**

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**ISSUE #12 – SB 371, Interpreter services**

**Rule:** 436-030-0115(4)(c), Reconsideration of Notices of Closure

**Issue/Background:** SB 371 also requires the insurer or self-insured employer to pay the cost of necessary interpreter services for the worker’s deposition at reconsideration. The division added this language to *temporary* OAR 436-030-0115(4)(c).

Is the language in the temporary rule sufficient to implement this part of SB 371?

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendation:**

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**ISSUE #13 – Post-training claim closures**

**Rule:**  
436-030-0020(14)

**Issue:** Does this rule need to be revised in light of [\*Liberty Northwest Ins. Corp. v. Olvera-Chavez\*](#), 267 Or App 55 (2014)?

**Background:** ORS 656.268(10) provides that a claim must be re-closed when the worker is no longer in training, and permanent disability is redetermined for work disability only. The Court of Appeals has interpreted this provision, together with ORS 656.268(1), to require both a redetermination of the worker’s medically stationary status and a closing medical examination for the purpose of redetermining work disability. The court stated in footnote 6, “To the extent that the ARU’s interpretation of OAR 436-030-0020[(14)](c) conflicts with our conclusion that a closing examination is required under ORS 656.268, the director’s interpretation is neither plausible nor entitled to deference.”

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendation:**

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**Housekeeping**

- 436-030-0015(1)(c)(A)(iii), Insurer Responsibility – This language should have been updated with other rule changes adopted effective March 1, 2015, to reflect *Brown v. SAIF*, to focus on the “compensable injury” instead of the accepted conditions.
- 436-030-0020(2), (2)(b), (4), (5), (13)(a)(B) – spacing, punctuation
- 436-030-0020(9)-(14) – section numbering
- 436-030-0023(4) – cross-reference
- 436-030-0023(5)(c) – grammar
- 436-030-0023(7) – spacing
- 436-030-0125(7)-(10) – section numbering
- 436-030-0135(3)(a) – grammar
- 436-030-0145(2)(b), (3)(a), (3)(c), (6)(b) – punctuation
- 436-030-0165(10) – replace cross-reference to 436-009-0015 (which no longer exists) with 436-009-0010
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**DIVISION 060 (CLAIMS)**  
**ISSUES DOCUMENT FOR 2015 LEGISLATIVE CHANGES**

**ISSUE #1 – OAR 436-060-0012**

**Issue:** Should the director amend this rule to specify where the Notice of Closure for a worker who has died must be sent, and to address the possible provision of Notice of Closure copies to the worker’s beneficiaries?

**Background:** Senate Bill 371, relating to notice of closure of workers’ compensation claims, became effective May 21, 2015. SB 371 provides a worker’s beneficiaries the right to request reconsideration of a notice of closure after the worker has died, or to pursue a request for reconsideration filed by the worker before the worker died. In addition to requiring the worker’s copy of the notice of closure (addressed to the worker’s estate) to be mailed to the worker’s last known address, the new law provides that the insurer or self-insured employer “**may** mail copies of the notice of closure to any known or potential beneficiaries” to the estate.

The division adopted temporary Division 030 (“Claim Closure and Reconsideration”) rules to implement SB 371 provisions, effective May 21, 2015. To ensure consistency among the claims processing and claim closure rules, this rule addressing notices and correspondence following the death of a worker should be amended to reflect the new law. Since notices of acceptance/denial and closure are both addressed in 060-0012(2) although the latter isn’t applicable when a claim is denied, it may be helpful to split this rule to address the current and new requirements for each notice separately.

**Alternatives:**

- Amend 060-0012 as suggested.
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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #2 – OAR 436-060-0150(5)(a) and (b)**

**Issue:** Should the director amend this rule to provide that timely first payment of temporary disability (“time loss”) benefits must occur within 14 days of the employer’s notice or knowledge of the claim **and** of the worker’s disability?

**Background:** House Bill 2797, addressing the first payment of time loss benefits, will be effective January 1, 2016. Currently, an insurer or self-insured employer must make the first payment of time loss benefits within 14 days of the employer’s knowledge of the claim, if the attending physician or authorized nurse practitioner authorizes the time off work. HB 2797 links

initial payment of time loss to the date the worker begins missing work due to the injury, because the start of temporary disability does not always coincide with the filing of the worker's claim. Injured workers may file a claim but continue working without losing wages, or may not miss work until later. With HB 2797 changing the "first payment" timeframe to require payment no later than the 14<sup>th</sup> day after the employer's knowledge of the claim and of the worker's disability, this rule addressing timely payment of compensation should be amended.

A related question is whether any changes need to be made to Forms 801 or 827 to facilitate claims processing given this new "trigger" for timely first payment? The new law won't change what occurs (be applicable) in many claims, so form changes may not be necessary. If not, is anything else needed to facilitate timely processing under the dual "employer knowledge of claim/disability" standard?

**Alternatives:**

- Amend 060-0150 as suggested.
- Amend Forms 801 or 827.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #3 – OAR 436-060-0200(3) and (7)**

**Issue:** Should these two related rules be amended to address the specific situation when the director may assess a service company a civil penalty for violations of claims processing requirements?

**Background:** House Bill 2211, relating to civil penalties for service companies, will be effective January 1, 2016. Under ORS 656.745, the director may currently assess civil penalties against an employer, insurer, or managed care organization for violating workers' compensation statutes, rules, or orders of the director. The law limits civil penalties to \$2,000 for each violation or \$10,000 for all violations within any three-month period. HB 2211 adds service companies (that process claims for an insurer or self-insured employer) to the list of parties that the director may issue a civil penalty for violations. However, the penalty is limited to a single situation: violations identified in the director's annual audits of claims processing performance. Further, the bill only allows one such penalty for each separate violation; the responsible insurer or self-insured employer and its service company could not both receive a penalty for the same violation identified in an annual audit. HB 2211 is permissive and does not require the department to change audit practices or penalty procedures, so potential rule amendments would state the director "may" assess a civil penalty to the service company in this sole situation.

**Alternatives:**

- Amend 060-0200(3) and (7) as suggested.

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- Only one of the two rules needs to be amended; do not amend 060-0200(*specify*).
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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE # 4 – OAR 436-060-0200(4)**

**Issue:** Should this rule be amended to address the director’s ability to assess a civil penalty to a service company for violations of referenced rules related to time frame requirements, if identified in an annual audit?

**Background:** This rule currently provides that the director may assess a civil penalty to an employer or insurer for failing to meet the time frame requirements in other specified rules, including 060-0010. Effective January 1<sup>st</sup>, HB 2211 (see #3) will allow the director to assess a penalty to a service company for violations identified in annual audits of claims processing performance. The director’s annual audit evaluates the timeliness of insurers’ and self-insured employers’ filing of all disabling, and denied nondisabling, claims based on the standards in 060-0010(10) and 060-0010(14). Thus, this rule should clarify that a service company may receive the civil penalty in lieu of the responsible insurer or self-insured employer, if the timely filing violations were identified in the annual audit.

**Alternatives:**

- Amend 060-0200(4) as suggested.
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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #5 – OAR 436-060-0200(6)**

**Issue:** Should this rule be amended to reflect that the director may assess the civil penalty for inaccurately reporting “timeliness of first payment” information to the service company processing the claims, in lieu of the insurer?

**Background:** As summarized above in #3 and #4, HB 2211 will allow the director to assess 656.745 civil penalties to service companies for violations identified in annual audits of claims processing performance. The accuracy of timely first payment reporting by insurers and self-insured employers addressed in this rule is one of the categories reviewed in the division’s

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annual audit. Under the new law, the division could assess the civil penalty for violations of this audit category to either the service company or the responsible insurer or self-insured employer.

**Alternatives:**

- Amend 060-0200(6) as suggested.
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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

**HOUSEKEEPING CHANGES**

HB 2211 changed the current references to “third party administrators” in ORS 656.780 (certification of claims examiners) to “service companies” because the Insurance Code uses the former term for life and health insurance claims, while stating that service companies process workers’ compensation claims. We suggest the same change be made to the following rules:

- OAR 436-060-0005(15)
- OAR 436-060-0009(2) and (4)(a)
- OAR 436-060-0010(9) and (21)
- OAR 436-060-0015(3) and (7)
- OAR 436-060-0017(3)
- OAR 436-060-0035(1)(g)
- OAR 436-060-0500(1)

**DIVISION 075 – RETROACTIVE PROGRAM  
RULEMAKING FOR LEGISLATIVE BILLS EFFECTIVE JANUARY 2016**

**ISSUE #1 – OAR 436-075-0005(11)**

**Issue:** Should the definition for “spouse” be amended to reflect changes made by HB 2478?

**Background:** HB 2478, awaiting the Governor’s signature, will require the use of gender neutral language with respect to legally recognized marriages, effective January 1, 2016. Assuming the Governor signs the bill, it is suggested that 075-0005(11) be amended to replace “the husband or wife of a worker” with terms used in the bill. For example, “spouses married to each other” or “spouses in a marriage” are options. Other non-workers’ compensation statutes and rules may provide other appropriate options, including “two persons married to each other.” The term “spouse” is currently used in 075-0005(10), so updating the definition in (11) should be sufficient. The remainder of Div. 075 refers to the worker’s beneficiaries.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**DIVISION 075 – ADDENDUM (NON-LEGISLATIVE CHANGE)**

**ISSUE #2 – OAR 436-075-0020**

**Issue:** Should this rule be amended to require insurers, self-insured employers, or the service companies processing their claims to conduct “alive and well” checks on deceased workers’ spouses every two years? If so, should similar checks also be done for children and dependents receiving monthly payments? Does the rule need to clarify the nature of the status check(s)?

**Background:** Division 030 (“Claim Closure and Reconsideration”) rules require insurers to reexamine permanent total disability claims at least once every two years. For deceased workers’ claims, insurers’ largest continuing payment obligations are often death benefits paid to the surviving spouse, if any. Insurers are reimbursed quarterly from the Worker Benefit Fund’s (WBF) Retroactive Program for the non-statutory portion of the monthly benefit. Over time, the annual “cost-of-living” increases paid by that program constitute a growing portion of the monthly benefit.

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Some, but not all, insurers and service companies conduct periodic status checks on surviving spouses. WCD has addressed three situations where an elderly spouse died and no one notified the insurer or the division. In two cases, an adult child continued to cash the monthly checks. One situation continued for six years and created a \$144,000 Retroactive overpayment. In the second case, the department recovered almost \$23,000 in a just-in-time lien on the sale of the widow's home; here, the service company identified the fraud during a wellness check. In the third case, the service company learned through civil court documents that the widow had been cohabitating since the late 1990s and had a child by the companion. Even with court judgments, WCD was not able to collect \$66,000 in over-reimbursed Retroactive payments. These examples don't address the sums the insurers were not able to recover.

Insurers and service companies usually monitor the ages of children receiving benefits to ensure they end at the appropriate time (based on age and schooling parameters). However, the division's interests in requiring status checks for spouses may also apply to children and dependents receiving benefits that are partially reimbursed from the Retroactive Program. It would be helpful for the committee(s) to provide input on both options: requiring checks for spouses only, or for all recipients of death benefits.

Separately, WCD and the Injured Worker Ombudsman occasionally receive complaints about overly-intrusive status checks on older spouses, sometimes by contracted vendors. In these cases, the intent of status checks is to verify that the intended recipients of these long-term payments are still alive. Doing so seems both reasonable and prudent, will benefit insurers and WCD, and ensure that WBF/Retroactive benefits funded by workers and employers are only paid to the appropriate survivors.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**DIVISION 100 – WORKERS’ COMPENSATION BENEFITS OFFSETS  
RULEMAKING FOR LEGISLATIVE BILLS EFFECTIVE JANUARY 2016**

**ISSUE #1 – OAR 436-100-0005(2)**

**Issue:** Should the definition for “beneficiary” be amended to reflect changes made by HB 2478?

**Background:** HB 2478, awaiting the Governor’s signature, will require the use of gender neutral language with respect to legally recognized marriages, effective January 1, 2016. Assuming the Governor signs the bill, it is suggested that 100-0005(2) be amended to replace “the husband, wife” with some variation of the terms used in the bill. For example, “a spouse married to the worker” is an option. Other non-workers’ compensation statutes and rules may provide other appropriate options.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**HOUSEKEEPING CHANGES**

**OAR 436-100-0040(2)**

Replace reference to “him” with “the worker.”

## Rule extracts

### **Issue #2 – division 030**

#### **436-030-0005 Definitions (*Temporary Rule*)**

- (9) “Notice of Closure” means a notice to the worker 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.

### **Issues #3 and #4 – division 030**

#### **436-030-0015 Insurer Responsibility (*Temporary Rule*)**

(1) When an insurer issues a Notice of Closure (Form 440-1644, 1644c, 1644r), the insurer is responsible for:

(c) Issuing the Updated Notice of Acceptance at Closure on the same date as the Notice of Closure.

(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:

(ii) Information: Names of all known beneficiaries, the beneficiaries’ right to and the extent of fatal benefits due under ORS 656.204 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.**

**If you disagree with the claim closure, you ~~A beneficiary who was mailed this notice may request reconsideration of the notice by~~ appeal the decision to 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.”**

## Rule extracts

### **Issue #5 – division 030**

#### **436-030-0020 Requirements for Claim Closure (*Temporary Rule*)**

(5) The “Notice of Closure,” Form 440-1644 (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:

(j) The worker’s appeal rights of the worker and any beneficiaries;

(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; and

(b) Copies of the notice may be mailed to any known or potential beneficiaries to the worker’s estate.

(109) The worker’s and any beneficiaries’ copy of the Notice of Closure must be mailed by both regular mail and certified mail return receipt requested.

### **Issue #13 – division 030**

(143) If after claim closure, the worker becomes enrolled and actively engaged in an approved training program under OAR 436-120, a new Notice of Closure must be issued consistent with the following:

(a) In claims with dates of injury on or after January 1, 2005, the insurer must redetermine work disability when:

(A) The worker has ended training; and either

(B) The worker<sup>2</sup> is medically stationary; or

(C) The claim otherwise qualifies for closure in accordance with these rules.

(b) For claims with dates of injury before January 1, 2005, permanent disability must be redetermined by the insurer when:

(A) The worker has ended training; and either

(B) The worker is medically stationary; or

(C) The claim otherwise qualifies for closure in accordance with these rules, except

(D) When the worker became medically stationary after June 7, 1995 for a scheduled disability. Then the scheduled disability must remain unchanged from the last award of compensation in that claim unless the condition did not remain medically stationary through training.

(c) For claims with dates of injury before January 1, 2005, if the worker has remained medically stationary throughout training and the closing examination is six months old or older, a current medical examination is required for redetermination unless the worker’s

## Rule extracts

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

### **Issue #7 – division 030**

#### **436-030-0023 Correcting and Rescinding Notices of Closure (*Temporary Rule*)**

(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 ~~60-day~~ 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 ~~60-day~~ 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.

(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 ~~60-day~~ 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.

## Rule extracts

### **Issue #8 – division 030**

#### **436-030-0115 Reconsideration of Notices of Closure (*Temporary Rule*)**

(1) A worker, ~~or insurer, or beneficiary~~ may request reconsideration of a Notice of Closure 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).

### **Issue #12 – division 030**

(4) The worker may submit a deposition to the reconsideration record subject to ORS 656.268(6) and the following:

(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, ~~and~~ the costs for the original transcript and one copy for each party its copies, 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.

### **Issue #8 – division 030**

#### **436-030-0125 Reconsideration Form and Format (*Temporary Rule*)**

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:

(7) If the request is made by a beneficiary of the worker, the name of the beneficiary and the beneficiary's attorney, if any;

### **Issue #9 – division 030**

#### **436-030-0135 Reconsideration Procedure (*Temporary Rule*)**

(1) Within 14 days from the date of the director's notice of the start of the reconsideration proceeding, the insurer must provide the director and the worker or the worker's attorney, or the beneficiary or beneficiary's attorney if the request was made by the beneficiary, in chronological order by document date, all documents pertaining to the claim which include, but are not limited to, the complete medical record and all official action and notices on the claim.

### **Issue #10 – division 030**

#### **436-030-0145 Reconsideration Time Frames and Postponements (*Temporary Rule*)**

(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.

## Rule extracts

(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 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 61<sup>st</sup> 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 or beneficiary instructing the director to start the reconsideration proceeding.

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### **Issue #1 – division 060**

#### **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 address all future notices and correspondence to the worker's estate or qualified beneficiaries.

(2) If a worker is deceased, regardless of the cause of death, an insurer must still provide a written notice of acceptance or denial of a claim and issue a Notice of Closure, when applicable, to the estate of the worker.

(3) Other notices required under this chapter intended for the worker are not required when the worker is deceased.

### **Issue #2 – division 060**

#### **436-060-0150 Timely Payment of Compensation**

(5) Timely payment of temporary disability benefits means payment has been made no later than the 14th day after:

(a) The date of the employer's notice or knowledge of the claim, provided the attending physician or authorized nurse practitioner has authorized temporary disability. Temporary disability accrued prior to the date of the employer's notice or knowledge of the claim shall be due within 14 days of claim acceptance;

## Rule extracts

(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;

### **Issues #3, 4, and 5 – division 060**

#### **436-060-0200 Assessment of Civil Penalties**

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

(4) An employer or insurer failing to meet the time frame requirements set forth 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 may be assessed a civil penalty 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 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. 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 or insurer who does not comply with the claims processing requirements of ORS chapter 656, and rules and orders of the director relating thereto may be assessed a civil penalty of up to \$2,000 for each violation or \$10,000 in the aggregate for all violations within any three month period.

Insert name, address, and phone number of insurer:

# Notice of Closure

Worker \_\_\_\_\_

[1] Date of closure (mailing date):

Worker name:

Date of injury:

Insurer's claim no.:

WCD file no.:

Employer:

**Your workers' compensation claim is now closed. We reviewed medical and other information about your compensable injury and determined the extent of your disability. This closure applies to the most recent period when your claim was open. If you have questions about this, you can call us or anyone listed on the back of this notice.**

*Time loss and disability are determined based on Oregon law.*

[2]

**We may deduct overpaid workers' compensation benefits from any current or future workers' compensation benefits you are due under ORS 656.268.**

[3] You became medically stationary on:	or	[4] Date your claim qualified for closure for reasons other than becoming medically stationary:	[5] Your aggravation rights end:
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**[6] IMPORTANT NOTICE: As the worker, you have the right to appeal this Notice of Closure by requesting reconsideration. You must make your request within 60 days from the mailing date of this notice. See the back of this notice for information on how to appeal.**

cc: <input type="checkbox"/> Worker – regular mail	<input type="checkbox"/> Worker's attorney	<input type="checkbox"/> Employer	<input type="checkbox"/> DCBS
<input type="checkbox"/> Worker – certified mail (return receipt requested)	<input type="checkbox"/> Beneficiary	<input type="checkbox"/> Insurer	

***Important legal document. Keep in a safe place.***  
**See "NOTICE TO WORKER" on the back of this form.**

# 1644

## NOTICE TO WORKER

This Notice of Closure is a legal document that closes your claim. It tells you the periods of time you qualified for temporary disability (time loss) and how much permanent disability you have, if any. See below to learn how a permanent disability award is paid.

**APPEAL RIGHTS:** If you disagree with this Notice of Closure, you have the right to appeal the closure of your claim by asking for a reconsideration within 60 days from the mailing date printed in box 1 on the front of this form. If you do not appeal within 60 days, you will lose all rights to appeal your claim closure. Form 2223A, "Worker Request for Reconsideration," is available from the Workers' Compensation Division in Salem or on the division's website: [www.wcd.oregon.gov/policy/bulletins/formsbyno.html](http://www.wcd.oregon.gov/policy/bulletins/formsbyno.html). To have the form mailed to you, call 503-947-7816 or write to the Workers' Compensation Division, Appellate Review Unit, 350 Winter St. NE, P.O. Box 14480, Salem, OR 97309-0405. After completing the form, mail or deliver it to the Appellate Review Unit or fax it to 503-947-7794. You have the right to have an attorney represent you during the appeal process.

You have the right to request a vocational eligibility evaluation by contacting us and requesting one. We may not be required to determine vocational eligibility if you have returned to regular work, have a regular work release, or you have no award of permanent disability. If you do request an eligibility evaluation, we will respond by 1) beginning your evaluation within five days and giving you our decision within 30 days or 2) notifying you within 14 days why you are not entitled to an evaluation.

As the insurer, we can also appeal this notice. We must make our request for review of the impairment findings portion within seven days of the mailing date in box 1 of this notice.

## NOTICE TO BENEFICIARIES

If the insurer mailed you a copy of this notice at the time the worker's claim was closed, you have the right to request reconsideration of this notice within 60 days from the mailing date printed in box 1 on the front of this form.

If the insurer did not mail you a copy of this notice at the time the claim was closed, you have the right to request reconsideration of this notice within one year of the date the notice was mailed to the estate of the worker.

Follow the instructions above after "Appeal Rights" to make your request.

### Frequently asked questions:

#### What are "scheduled," "unscheduled," and "whole-person" disability?

*Scheduled disability* is the loss of use or function of an arm, hand, leg, or foot, or the loss of visual or hearing ability. A "schedule" in the Oregon law lists these body parts with specific dollar amounts allowed for each part or for a percentage of loss of use for each part.

*Unscheduled disability* involves impairment of body parts or systems (such as the back, hip, or respiratory system). In addition to impairment, the calculation of unscheduled disability may include factors such as age, education, work history, and current ability to perform work.

*Whole-person disability* is permanent impairment of the whole person resulting from the loss of use or function of any portion of the body. In addition to impairment, we may award a value for work disability (impairment and factors of age, education, work history, and the current ability to work) when you do not return to the job you were doing when you were injured.

#### How do we pay permanent disability awards?

If an award is less than or equal to \$6,000, we will pay the entire amount, minus any money we overpaid you, within 30 days from the mailing date on this notice. If the award is more than \$6,000, we will make monthly payments after we recover any overpayment. The award payments will begin within 30 days of the mailing date on this notice. If you want the whole award paid to you at one time, you may ask us for a "lump-sum payment." NOTE: If you ask for and accept a lump-sum payment of an award that is more than \$6,000, you give up your right to appeal your permanent disability award.

#### What if you still need medical care?

We are responsible for future medical services with some limitations. We or your doctor can tell you which medical services are covered.

#### More questions?

- You may contact us if you have questions about this Notice of Closure or your rights and responsibilities.
- You may also contact a benefit consultant at the Workers' Compensation Division, 503-947-7585 or 800-452-0288 (toll-free).
- The Ombudsman for Injured Workers can help you understand your rights. You may call the Ombudsman at 503-378-3351 or 800-927-1271 (toll-free) to get help or to set up an appointment.
  - ◆ There is no charge for help from the Ombudsman's office or the Workers' Compensation Division.
- You should have received the brochure *Understanding Claim Closure and Your Rights* with this Notice of Closure. Another brochure, *What happens if I'm hurt on the job?*, will give you additional information. To get a copy of these brochures, call 503-947-7627 or go to the Workers' Compensation Division's website: [www.wcd.oregon.gov/pubs.html](http://www.wcd.oregon.gov/pubs.html).

# Notice of Closure Permanent Total Disability Reduction

Worker \_\_\_\_\_

[1] Date of closure (mailing date):

Worker name:

Date of injury:

Insurer's claim no.:

WCD file no.:

Employer:

**Your workers' compensation claim is now closed. We reviewed your claim and determined that you are able to regularly perform work at a gainful and suitable job. Since you no longer qualify for permanent total disability benefits, we calculated the extent of your permanent partial disability. This notice applies to the most recent open period of your claim. If you have questions about this, you can call us or anyone listed on the back of this notice.**

*Time loss and disability are determined based on Oregon law.*

[2] Date of PTD status determination:

[3]

**We may deduct overpaid workers' compensation benefits from any current or future workers' compensation benefits you are due under ORS 656.268.**

[4] Your condition became medically stationary on:

[5] Your aggravation rights end:

**[6] IMPORTANT NOTICE: You have the right to appeal this Notice of Closure by requesting a hearing. You must make your request within 60 days from the mailing date of this notice unless otherwise specified on the back of this form.**

cc:  Worker – regular mail       Employer       DCBS  
 Worker – certified mail (return receipt requested)       Insurer       Other:

***Important legal document. Keep in a safe place.***  
**See "NOTICE TO WORKER" on the back of this form.**

**1644p**

## NOTICE TO WORKER

This "Notice of Closure" is a legal document that closes your claim. It tells you the periods of time you qualified for temporary disability (time loss) and how much permanent disability you have, if any. See below to learn how a permanent disability award is paid.

**APPEAL RIGHTS:** If you disagree with this notice of closure, you have the right to appeal the closure of your claim. All appeal periods begin on the date in box 1 of this notice. To appeal when your medically stationary date is:

- On or after July 2, 1990, and before June 7, 1995, you must request reconsideration within 180 days of the date in box 1.
- On or after Jan. 1, 1988, and on or before July 1, 1990, you must request a hearing from the workers' compensation board within 180 days of the date in box 1.
- Prior to Jan. 1, 1988, you must request a hearing from the workers' compensation board within one year of the date in box 1.

If you do not appeal within the correct period, you will lose all rights to appeal your claim closure. To request a hearing, you must make your request in writing and mail or deliver it to: Workers' Compensation Board, Hearings Division, 2601 25<sup>th</sup> St., Suite 150, Salem, OR 97302-1280.

Since your permanent total disability benefits are being terminated, you will be eligible for vocational assistance when this Notice of Closure or an order upholding termination of your permanent total disability benefits becomes final. If you have questions about your rights to vocational assistance, you may contact us.

You have the right to have an attorney represent you during the appeal process.

### Frequently asked questions:

#### What are "scheduled," "unscheduled," and "whole-person" disability?

*Scheduled disability* is the loss of use or function of an arm, hand, leg, or foot, or the loss of visual or hearing ability. A "schedule" in the Oregon law lists these body parts with specific dollar amounts allowed for each part or for a percentage of loss of use for each part.

*Unscheduled disability* involves impairment of body parts or systems (such as the back, hip, or respiratory system). In addition to impairment, the calculation of unscheduled disability may include factors such as age, education, work history, and current ability to perform work.

*Whole-person disability* is permanent impairment of the whole person resulting from the loss of use or function of any portion of the body. In addition to impairment, we may award a value for work disability (impairment and factors of age, education, work history, and the current ability to work) when a worker does not return to the job he or she was doing when he or she was injured.

#### How do we pay permanent disability awards?

If an award is less than or equal to \$6,000, we will pay the entire amount, minus any money we overpaid you, within 30 days from the mailing date on this notice. If the award is more than \$6,000, we will make monthly payments after we recover any overpayment. The award payments will begin within 30 days of the mailing date on this notice. If you want the whole award paid to you at one time, you may ask us for a "lump-sum payment."

NOTE: If you ask for and accept a lump-sum payment of an award that is more than \$6,000, you give up your right to appeal your permanent disability award.

#### What happens to your monthly benefits?

Your monthly benefits stop as of the date of the Notice of Closure that determined you are no longer due permanent total disability benefits, unless you appeal this notice within the first 30 days after issuance. If you appeal this order between 30 and 60 days after issuance, we must restart and continue monthly payments until reduction of your permanent total disability award becomes final.

#### What if you still need medical care?

We are responsible for future medical services with some limitations. We or your doctor can tell you which medical services are covered.

### More questions?

- You may contact us if you have questions about this Notice of Closure or your rights and responsibilities.
- You may also contact a benefit consultant at the Workers' Compensation Division, 503-947-7585 or 800-452-0288.
- The Ombudsman for Injured Workers can help you understand your rights. You may call the Ombudsman at 503-378-3351 or 800-927-1271, to get help or set up an appointment.
  - ◆ There is no charge for help from the Ombudsman's office or the Workers' Compensation Division.



Workers' Compensation Division

# Worker Request for Reconsideration

There can be only one reconsideration proceeding by the Workers' Compensation Division (WCD) for any claim closure. All parties can raise issues and provide evidence within the statutory time limits. When permanent disability is raised, WCD will automatically review the compensable injury for temporary rating standards. For help filling out this form, contact the Appellate Review Unit, 503-947-7816, or the Ombudsman for Injured Workers, 503-378-3351 or 800-927-1271 (toll-free). Complete and send a signed copy of this form, along with any information you want reviewed, to: Appellate Review Unit, Workers' Compensation Division, 350 Winter St. NE, P.O. Box 14480, Salem, Oregon 97309-0405, or fax to 503-947-7794 (Note: fax limit of 25 pages). If you have an attorney, include a current signed retainer agreement.

## Claim identification

Worker's name: _____	WCD no.: _____	Date of injury: _____
Address: _____	Worker's date of birth: _____	
	Insurer claim no.: _____	
Phone no.: _____	Insurer name: _____	
Email: _____	Email: _____	
Worker's attorney (if any): _____	Insurer's attorney (if known): _____	
Address: _____	Address: _____	
Phone no.: _____	Phone no.: _____	
Email: _____	Email: _____	

## Reconsideration of closure (Check all boxes that apply. See back of this form for definitions.)

I request reconsideration of the Notice(s) of Closure (NOC) dated: \_\_\_\_\_

- I have special language needs. Please identify your language need: \_\_\_\_\_
- I have asked for and received a "lump-sum" (full) payment of my permanent disability award.
- I will be scheduling a worker deposition.
- I initiated this request by phone.

## Issues (Check all issues you want reviewed. If you do not check a box, your right to dispute that issue ends.)

- 1. The insurer closed my claim too soon or closed it improperly (Example: not medically stationary).
- 2. I disagree with the medically stationary or statutory closure date on the NOC. Correct date: \_\_\_\_\_
- 3. I disagree with the temporary disability dates shown on the NOC. Correct dates: \_\_\_\_\_
- 4. I disagree with the impairment findings used to determine and rate permanent disability. I want to be examined by a medical arbiter. I want a panel exam. Yes  No
- 5. I disagree with the rating of permanent disability and understand that by marking this box I will **not** be scheduled for a medical arbiter exam.
- 6. I have other issue(s) with the NOC (Examples: I disagree with specific elements of work disability, I believe I am permanently and totally disabled). Please explain: \_\_\_\_\_

**Notice to all parties:** A request for reconsideration automatically includes review of the appropriateness of the closure under ORS 656.268 (e.g., medically stationary, sufficient information to close).

**Notice to the worker:** The insurer also may request reconsideration of its Notice of Closure and must do so within seven days of the mailing date of the Notice of Closure. Reconsideration includes a review of the whole record and may result in no change, a decrease, or an increase in your benefits. Mail, fax, phone, or hand-deliver your request within 60 days of the Notice of Closure, according to OAR 436-030-0005. You must send a copy of your request and any information you want reviewed to the insurer at the same time you send it to the Workers' Compensation Division.

\_\_\_\_\_  
Signature of worker, requester, or designee

\_\_\_\_\_  
Date

CC:

## Completion instructions, definitions, and other information (\*Notes required information)

### Claim identification

#### \*Worker's name, address, and phone number

This information is important to make sure all parties receive or can provide appropriate and timely information. The parties must provide updated information to each other and the division whenever something changes.

#### WCD number

The Workers' Compensation Division assigns this number when the 801 form is filed with the department. (This is a different number than the insurer claim number.) This number may appear on the front of the Notice of Closure.

#### \*Insurer claim number

The insurance company assigns this number to the claim. It is a different number than the WCD number the department assigns to the claim.

#### Insurer attorney's (if known) name, address, and phone number

You can obtain this information from the insurance company or from the front of the Notice of Closure.

#### Email

Provide email addresses where messages are read and responded to regularly and promptly.

### Reconsideration of closure

#### \*Notice of Closure (NOC) date

This is the "mailing date" in the upper right-hand corner of the NOC. The insurer may also have sent you a Correcting NOC, a Rescinding and Reissuing NOC, or both. Put the "mailing date" of all NOCs you want to appeal on the same line.

#### Special language needs

Describe any special language needs you may have, including sign language.

#### Lump-sum payment

Permanent partial disability (PPD) cannot be reviewed at reconsideration if:

- Your PPD award is more than \$6,000 and
- You request and accept a lump-sum payment from the insurer

#### Deposition

This is testimony under oath (not in a court) generally in a question-and-answer format. All parties can ask questions. The deposition is typed by a stenographer. You must schedule the deposition and notify the insurer. The insurer pays the costs.

### Issues

#### Premature or improper closure

Your claim was closed too soon. You are not medically stationary, or your claim was not closed in accordance with the law. For example, there was not enough information to determine your disability.

#### Medically stationary date

This is the date your doctor says that your condition(s) will not improve with further medical treatment or the passage of time. It may not mean you are back to normal, but no further treatment is likely to help.

### Statutory closure date

According to Oregon law, the claim can be closed whether your condition is medically stationary or not, when any of the following occur:

- The compensable injury is no longer the major cause of your need for treatment and there is enough information to determine the extent of disability
- You do not seek medical treatment for 30 days – for reasons within your control – without the attending physician's approval
- A mandatory closing examination is scheduled and you miss it for reasons within your control

### Temporary disability dates

These are the periods of time your attending physician has told your insurer that you are either unable to work (temporary total disability) or able to do only modified work (temporary partial disability).

### Medical arbiter exam

This exam is performed by a physician who has not seen you for this claim. The physician is chosen by the division to help settle disputes about permanent disability.

### Impairment findings and rating

These are issues specific to permanent partial disability (PPD).

### Panel exam

Check the yes box if you want a panel of doctors to perform a medical arbiter exam.

### Other issues

Use this space if you are raising other issues related to the closure, such as specific elements of work disability or permanent total disability (PTD) status.

### Temporary rating standard

This is a claim-specific standard researched by the Appellate Review Unit. It is included in the reconsideration order to rate permanent disability not otherwise addressed in OAR 436-035, Disability Rating Standards.

### Copies (cc)

List the parties to whom you are sending copies of the form and other information.

### Other important information

#### You disagree with the information or medical evidence used at claim closure. What can you do?

You can do one or more of the following:

- Explain why the information is incorrect
- Send clarifying information from the attending physician
- Send medical evidence that should have been included at the time of closure

This is your last chance to add information to the record for review or future appeals.

#### You disagree with something you did not raise in your request for reconsideration. What can you do?

You **cannot** raise any issue about the NOC in future appeals if you **did not** raise it at reconsideration.



Workers' Compensation Division

# Insurer Request for Reconsideration

Insurers must submit a request for reconsideration within seven days of the mailing date of the Notice of Closure (NOC) to: Appellate Review Unit, Workers' Compensation Division, 350 Winter St. NE, P.O. Box 14480, Salem, Oregon 97309-0405, or fax to 503-947-7794 (Note: fax limit of 25 pages).

## Claim identification

Worker's name: _____	WCD no.: _____	Date of injury: _____
Address: _____	Worker's date of birth: _____	
	Insurer claim no.: _____	
Phone no.: _____	Insurer name: _____	
Email: _____	Email: _____	
Worker's attorney (if known): _____	Insurer's attorney (if any): _____	
Address: _____	Address: _____	
Phone no.: _____	Phone no.: _____	
Email: _____	Email: _____	

## Reconsideration of closure (Check all boxes that apply.)

We request reconsideration of the NOC(s) dated: \_\_\_\_\_

The worker has special language needs. Please identify language need: \_\_\_\_\_

We request a panel exam.

## Issues

The only issue for which an insurer can request reconsideration is the impairment findings used to determine permanent disability. The division will schedule a medical arbiter exam and rate permanent disability. The division will automatically review the compensable injury for temporary rating standard(s).

**Notice to all parties:** A request for reconsideration automatically includes review of the appropriateness of the closure under ORS 656.268.

**Notice to the worker:** The insurer is requesting reconsideration of the Notice of Closure (NOC). (See back of this form for definitions.)

Reconsideration includes a review of the whole record and the identified above. All parties can raise issues and provide evidence within the statutory time limits. The review may result in no change, a decrease, or an increase in benefits.

You also may request reconsideration of the NOC by submitting your request by mail, fax, phone, or hand-delivery within 60 days from the mailing date of the NOC. Form 2223a, "Worker Request for Reconsideration," is available online: [www.wcd.oregon.gov/policy/bulletins/formbyno.html](http://www.wcd.oregon.gov/policy/bulletins/formbyno.html). For help getting this form or filling it out, contact the Appellate Review Unit, 503-947-7816, or the Ombudsman for Injured Workers, 503-378-3351 or 800-927-1271 (toll-free). Mail or hand-deliver it to the Appellate Review Unit, Workers' Compensation Division, 350 Winter St. NE, P.O. Box 14480, Salem, Oregon 97309-0405, or fax to 503-947-7794 (Note: fax limit of 25 pages). If you request reconsideration, you must send a copy of your request and any information you want reviewed to the insurer at the same time you send it to the Workers' Compensation Division.

\_\_\_\_\_  
Signature of requester or designee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Typed/printed name of requester or designee

\_\_\_\_\_  
Phone

CC:

## Completion instructions, definitions, and other information

### Claim identification

#### Worker's name, address, and phone number

This information is important to make sure all parties receive or can provide appropriate and timely information. The parties must provide updated information to each other and the division whenever something changes.

#### WCD number

The Workers' Compensation Division assigns this number when the 801 form is filed with the department. (This is a different number than the insurer claim number.)

#### Insurer claim number

The insurance company assigns this number to the claim. It is a different number than the WCD number the department assigns to the claim.

#### Email

Provide email addresses where messages are read and responded to regularly and promptly.

### Reconsideration of closure

#### Notice of Closure (NOC) date

This is the "mailing date" in the upper right-hand corner of the NOC. The insurer may also have sent a Correcting NOC, a Rescinding and Reissuing NOC, or both. If there is more than one "mailing date" on the same line, the insurer is appealing those notices, as well.

#### The worker has special language needs

The insurer marks this box if any special language needs exist, including sign language.

#### Panel exam

The insurer checks this box when it wants a panel of doctors to perform a medical arbiter exam.

### Issues

#### Impairment finding

This measures permanent loss of use or function of a body part or system related to the compensable injury.

#### Medical arbiter exam

This exam is performed by a physician who has not seen the worker for this claim. The division chooses the physician to help settle disputes about permanent disability.

#### Temporary rating standard

This is a claim-specific standard researched by the Appellate Review Unit. It is included in the reconsideration order to rate permanent disability not otherwise addressed in OAR 435-035, Disability Rating Standards.

### Copies (cc)

List the parties to whom you are sending copies of the form and other information.

### Other important information

#### The insurer disagrees with the medical impairment finding(s) used to determine disability. What happens now?

The Appellate Review Unit schedules an exam with a medical arbiter. The exam includes a review of the medical records and is the basis for determining permanent impairment, if any. Medical arbiter physicians cannot offer any medical treatment. They report their findings to the appellate reviewer, the insurer, and you or your attorney. (Sometimes they only review the record.)

#### The worker disagrees with something the worker did not raise in his or her request for reconsideration. What can the worker do?

The worker **cannot** raise any issue about the NOC in future appeals if the worker **did not** raise it at reconsideration.

#### The worker has more information the worker wants reviewed during reconsideration. What can the worker do?

This is the worker's last chance to add to and correct information in the record for this review or future appeals. Any party sending information to the division must copy all other parties.

#### The worker disagrees with the information or medical evidence used at claim closure. What can the worker do?

The worker can do one or more of the following:

- Explain why the information is incorrect
- Send clarifying information from the attending physician
- Send medical evidence that should have been included at the time of closure