

436-060-0017(1) (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.

"Documents" also includes audio and video recordings of the alleged injury incident and the worker's entire personnel file, including payroll and time-keeping records, and surveillance video obtained prior to a request for hearing.

(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. **The insurer is deemed to be in "Possession" of any "Documents" subject to the control of the employer.** 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.

436-060-0017(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 the duration of the claim or until notified that the worker is no longer represented—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).

436-060-0020(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 shall** 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).

436-060-0030(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.

(e) The employer provides a written explanation to the worker as to the reason for the termination and provides copies of all documentation relied upon in making the decision to terminate the worker.

(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 **and provide a copy of** 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 **discontinuation of benefits**, changes in the compensation rate, and the method of computation, whenever a change is made.

436-060-0095(15) No Insurer medical examination shall be scheduled more than 50 miles from an injured worker's current residence without prior authorization from the director. The director shall give authorization for an examination more than 50 miles away from the worker's current residence only if the insurer can establish that there are no examiners who could perform the examination in a location closer to the injured worker.

436-060-0140(10)(e) If a notice of denial of a claim fails to comply with the requirements set forth above in paragraphs (10)(a)(A) - (C) of this rule, such noncompliance satisfies the requirements set forth in OAR 436-060-0147(2)(e).

436-060-0147(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 ~~supported by~~ **based on** one or more Independent Medical Examination reports with which the attending physician or authorized nurse practitioner disagreed, **or the denial did not contain the information required by OAR 436-060-0140(10)(a)(A) – (C).**

(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). **Concurrence by the attending physician or authorized nurse practitioner with the independent medical examination report(s) must be a complete concurrence in all respects. Failure by the insurer to determine whether the attending physician or authorized nurse practitioner concurs with the independent medical examination report(s) in all respects shall be the same as a non-concurrence.**

436-060-0150 (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 for which 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.

If work restrictions are lifted or authorization of temporary disability is no longer valid, the insurer shall continue to issue temporary disability until notice is mailed to the worker. The notice shall identify the legal basis for discontinuing the disability payments and provide copies of any documents used to establish that temporary disability is no longer payable.

436-060-0400 (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. **Penalties and attorney fees under this section cannot be waived prospectively in a Claims Disposition Agreement or Disputed Claims Settlement.**

New rule.

ORS 436-060-xxxx : An employer has an obligation to cooperate in counsel's investigation of a worker's compensation claim on behalf of an injured worker, including but not limited to submitting to pre-hearing statements as approved by the director.