BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON

In the Matter of the Amendment of OAR: 436-030, Claim Closure and Reconsideration 436-060, Claims Administration 436-075, Retroactive Program 436-100, Workers' Compensation Benefits Offset	)))))	SUMMARY OF TESTIMONY AND AGENCY RESPONSES

This document summarizes the significant data, views, and arguments contained in the hearing record. The purpose of this summary is to create a record of the agency's conclusions about the major issues raised. Exact copies of the written testimony are attached to this summary.

The proposed amendment to the rules was announced in the Secretary of State's *Oregon Bulletin* dated September, 2015. On , a public rulemaking hearing was held as announced at 11 a.m. in Room F of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers' Compensation Division, acted as hearing officer. The record was held open for written comment through Sept. 28, 2015.

No one testified at the public rulemaking hearing, recorded below as exhibit 3. The public submitted one written document as testimony, exhibit #2.

Testimony list:

Exhibit	Testifying
1	Proposed rules, including Notice of Proposed Rulemaking Hearing and Statement of Need and Fiscal Impact
2	Lisa Wilch, SAIF Corporation
3	Hearing transcript

Testimony: OAR 436-030-0165(10) ***Exhibit 2***

"* * * It appears one of the citations in this rule no longer exists. The rules now jump from 436-009-0010 to 436-009-0018. [The current rule states] (10) All costs related to record review, examinations, tests, and reports of the medical arbiter must be paid under **OAR 436-009-0015**, 436-009-0040, and 436-009-0060."

Response: The comment is correct. OAR 436-009-0015 was repealed when the Medical Fee and Payment Rules were revised effective April 1, 2014. We have amended OAR 436-030-0165(10) to update the references to relevant rules in OAR 436-009 that apply to billing and payment for the costs of a medical arbiter examination.

Dated this 29th day of September, 2015.

Oregon
Kate Brown, Governor

Department of Consumer and Business Services
Workers' Compensation Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
1-800-452-0288, 503-947-7810
www.wcd.oregon.gov

Aug. 12, 2015

Exhibit "1"

Proposed Changes to Workers' Compensation Rules

Implementation of legislation affecting claim closure, timely payment of benefits, penalties, and gender-neutral wording

The Workers' Compensation Division proposes changes to OAR:

- **436-030, Claim Closure and Reconsideration**
- **436-060, Claims Administration**
- **436-075, Retroactive Program**
- **436-100, Workers' Compensation Benefits Offset**

Please review the attached documents for more information about proposed changes and possible fiscal impacts.

The department welcomes public comment on proposed changes and has scheduled a public hearing.

When is the hearing? Sept. 22, 2015, 11 a.m.

Where is the hearing? Labor & Industries Building
350 Winter Street NE, Room F (basement)
Salem, Oregon 97301

How can I make a comment? Come to the hearing and speak, send written comments, or do both. Send written comments to:
Email – fred.h.bruyns@oregon.gov
Fred Bruyns, rules coordinator
Workers' Compensation Division
350 Winter Street NE (for courier or in-person delivery)
PO Box 14480, Salem, OR 97309-0405
Phone – 503-947-7717; Fax – 503-947-7514

The closing date for written comments is Sept. 28, 2015.

How can I get copies of the proposed rules?

On the Workers' Compensation Division's website –

www.**wcd.oregon.gov/policy/rules/rules.html#proprules**

Or call 503-947-7717 to get free paper copies

Questions? Contact Fred Bruyns, 503-947-7717.

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Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form

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SECRETARY OF STATE

Department of Consumer and Business Services, Workers' Compensation Division — 436
Agency and Division — Administrative Rules Chapter Number

Fred Bruyns — (503) 947-7717
Rules Coordinator — Telephone

Department of Consumer and Business Services, Workers' Compensation Division, PO Box 14480, Salem, OR 97309-0405
Address

RULE CAPTION

Implementation of legislation affecting claim closure, timely payment of benefits, penalties, and gender-neutral wording

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

Hearing Date	Time	Location	Hearings Officer
9-22-15	11:00 a.m.	Room F Labor & Industries Building, 350 Winter St NE, Salem, Oregon	Fred Bruyns

RULEMAKING ACTION

Secure approval of rule numbers with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND:
OAR 436-030, 436-060, 436-075, 436-100

REPEAL:

RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

AMEND AND RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

Statutory Authority:
ORS 656.726(4), 656.727

Other Authority:

Statutes Implemented:
ORS chapter 656, as amended by SB 371 (2015 Or Laws, ch. 144), HB 2211 (2015 Or Laws, ch. 194), HB 2478 (2015 Or Laws, ch. 629), HB 2764 (2015 Or Laws, ch. 521), and HB 2797 (2015 Or Laws, ch. 211)

RULE SUMMARY

The public may also listen to the hearing or testify by telephone: Dial-in number is 213-787-0529; Access code is 9221262#.

The agency proposes to amend OAR 436-030, "Claim Closure and Reconsideration."
- In general, these rules:
  - Adopt May 21, 2015, temporary rules permanently;
  - Implement Enrolled Senate Bill 371 regarding the right of a worker's beneficiary to request reconsideration of a Notice of Closure;
  - Modify rules to be consistent with Sather v. SAIF, 357 Or 122 (2015), regarding the worker's estate's right to request reconsideration and Liberty Northwest Ins. Corp. v. Olvera-Chavez, 267 Or App 55 (2014), regarding claim closure after training; and
  - Make minor housekeeping changes.

- Specifically, these rules:
  - Redefine "Notice of Closure" from a "notice to the worker" to a "notice to the worker, estate, or beneficiary";
  - Modify the information that must be included in the Updated Notice of Acceptance at Closure consistent with statutory language;
  - Modify the requirements for the Updated Notice of Acceptance and Closure issued in an instant fatality to (1) remove the requirement to include names of all known beneficiaries and instead require a statement that beneficiaries may be entitled to benefits, and (2) include in required language the right of a beneficiary to request reconsideration of the Notice of Closure;
  - Modify and clarify the requirements for claim closure after an authorized training program following the Court of Appeals opinion in Liberty Northwest Ins. Corp. v. Olvera-Chavez, 267 Or App 55 (2014);

- Provide that a Notice of Closure is effective the date it is mailed to the worker or the worker's estate if the worker is deceased;
- Require the Notice of Closure to include appeal rights of beneficiaries;
- Provide to whom and how the Notice of Closure should be mailed if the worker is deceased;
- Provide for the possibility that a request for reconsideration may be filed by the worker, the worker's estate, or a beneficiary of the worker, and require the request to include the identity and name of the requester and the requester's attorney, if any;
- Require insurers and self-insured employers to pay costs for necessary interpreter services to prepare a deposition that is submitted to the reconsideration record;
- Require the insurer to distribute a copy of the record to be used for the reconsideration proceeding to the beneficiary or the beneficiary's attorney, or the estate or the estate's attorney, if the request for reconsideration was filed by the beneficiary or estate; and
- Specify that a request for reconsideration must be mailed by a beneficiary within 60 days of the mailing date of the Notice of Closure if the Notice was mailed to the beneficiary, or within 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.

The agency proposes to amend OAR 436-060, "Claims Administration," to:
- Implement Enrolled Senate Bill 371 by describing how to distribute a Notice of Closure issued after the death of a worker;
- Implement Enrolled House Bill 2211 by describing the director's authority to assess civil penalties against service companies, and by replacing references to "third-party administrator" with "service company";
- Implement Enrolled House Bill 2764 by addressing penalties and attorney fees related to untimely payment of attorney fees or costs;
- Implement Enrolled House Bill 2797 by specifying that the insurer or self-insured employer must pay temporary disability benefits within 14 days of the employer's knowledge of the claim and the worker's disability; and
- Make plain language changes to improve readability.

The agency proposes to amend OAR 436-075, "Retroactive Program," to:
- Implement Enrolled House Bill 2478 by amending the definition of "Spouse" to refer to the "spouse" of a worker rather than to the "husband or wife" of a worker;
- Update other definitions;
- Require that insurers verify, at least once every two years, that beneficiaries receiving permanent total disability or death benefits are alive and remain eligible for those benefits for which the insurer may request reimbursement from the Retroactive Program; and
- Make plain language changes to improve readability.

The agency proposes to amend OAR 436-100, "Workers' Compensation Benefits Offset," to:
- Implement Enrolled House Bill 2478 by amending the definition of "Beneficiary" to refer to the "spouse" of a worker rather than to the "husband" or "wife" of a worker;
- Update other definitions; and
- Make plain language changes to improve readability.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

09-28-2015 Close of Business	Fred Bruyns	fred.h.bruyns@oregon.gov
Last Day *(m/d/yyyy)* and Time for public comment	Rules Coordinator Name	Email Address

*The Oregon Bulletin is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation.

Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing accompanies this form.

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Department of Consumer and Business Services, Workers' Compensation Division — 436

Agency and Division — Administrative Rules Chapter Number

Implementation of legislation affecting claim closure, timely payment of benefits, penalties, and gender-neutral wording

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of:

Amendment of:
OAR 436-030, Claim Closure and Reconsideration
OAR 436-060, Claims Administration
OAR 436-075, Retroactive Program
OAR 436-100, Workers' Compensation Benefits Offset

Statutory Authority:

ORS 656.726(4), 656.727

Other Authority:

Statutes Implemented:

ORS chapter 656, as amended by SB 371 (2015 Or Laws, ch. 144), HB 2211 (2015 Or Laws, ch. 194), HB 2478 (2015 Or Laws, ch. 629), HB 2764 (2015 Or Laws, ch. 521), and HB 2797 (2015 Or Laws, ch. 211)

Need for the Rule(s):

Rule changes are needed to implement legislation passed by the 2015 Oregon Legislature and to more effectively administer existing workers' compensation laws and rules.

Documents Relied Upon, and where they are available:

Enrolled Senate Bill 371 (2015), Enrolled House Bill 2211 (2015), Enrolled House Bill 2764 (2015), Enrolled House Bill 2478 (2015), Enrolled House Bill 2797 (2015), and rulemaking advisory committee records. These documents are available for public inspection in the Administrator's Office, Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday.

Fiscal and Economic Impact:

Most of the proposed rule changes are intended to implement legislation passed by the 2015 Oregon Legislature, as well as recent court decisions. However, the agency has estimated fiscal and economic impacts without regard to whether those impacts result from the law change or court decisions. The agency projects very minor impacts overall. Please refer to the "Statement of Cost of Compliance" below.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

a. State agencies: The agency estimates that there will be no significant impact on state agencies.

b. Units of local government: The agency estimates that there will be no significant impact on units of local government except cities and counties that are self-insured employers; the estimated impact for self-insured employers is shown under "The public" below.

c. The public: The agency projects a small increase in costs to insurers, self-insured employers, and service companies - henceforth referred to as "insurers" - as a result of the following changes:

- Insurers will be required to modify the wording of the Notice of Acceptance and Closure that is issued if the worker dies immediately as a result of the accident. This cost impact is expected to be very small due to the small number of fatal on-the-job injuries.
- Insurers will be required to convert to a revised Notice of Closure, Form 1644, which has been modified to explain the rights of beneficiaries. This should be a minor, one-time cost that will vary according to insurers' processes. Modification of an electronic form or template should be less costly than having the form professionally printed.
- If insurers send copies of the Notice of Closure to the beneficiaries of a deceased worker, the copies must be mailed by certified mail, return receipt requested. This is the mailing standard for workers' copies of the Notice of Closure, so the cost impact will depend upon whether this is the insurer's current practice for beneficiaries or whether insurers begin mailing copies to beneficiaries as allowed by SB 371. Due to the small number of cases involved, any cost increases are expected to be small.
- The proposed rule changes in response to the Court of Appeals opinion in Liberty Northwest Ins. Corp. v. Olvera-Chavez, 267 Or App 55

(2014), primarily the requirement for a current determination of medically stationary status and residual functional capacity before a claim reopened for an authorized training program may be reclosed, may increase costs to close the claim. In 2014 fewer than 100 claims were closed following reopening for an authorized training program, so the overall cost impact should be small.
- Insurers will pay costs for necessary interpreter services to prepare a deposition that is submitted to the reconsideration record. The demand for such translation service is expected to be very limited and thus the cost impact will be small.
- Insurers will be required to pay penalties for unreasonable delay or unreasonable refusal to pay attorney fees or costs. Because the agency has no data regarding how often such delays occur, it cannot estimate the potential fiscal impact; however, any associated penalties will increase insurers' costs and provide a corresponding benefit to attorneys.
- The proposed rules will require insurers to verify that beneficiaries receiving death benefits or permanent total disability benefits, for which the insurer or self-insured employer may request reimbursement from the Retroactive Program, are alive and remain eligible for benefits. Most insurers currently conduct periodic wellness checks. To the extent insurers have not been doing so or are doing so less often than once every two years, the proposed requirement may slightly increase the insurers' costs. However, to the extent periodic wellness checks result in determinations that benefits are no longer payable, insurers' costs will be reduced.

The agency projects some redistribution of costs related to the issuance of civil penalties against service companies. Currently, the agency may only issue civil penalties for claims processing performance deficiencies revealed in annual audits to insurers and self-insured employers. With the passage of HB 2211 (2015), effective Jan. 1, 2016, the agency director may assess such penalties against service companies. To the extent the agency does so, service companies will be charged with paying the penalties, and there will be a corresponding reduction in penalties payable by insurers and self-insured employers. In practice, insurers and self-insured employers often pass along the costs of the penalties to their service companies, and to that extent there should be very little fiscal impact on the parties, though some efficiencies may result because the money does not have to change hands. The agency does not anticipate issuing more or fewer penalties and projects no significant net cost increase or decrease to the workers' compensation system.

The agency projects that additional proposed rule changes will not have significant fiscal or economic impacts on any party.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small business and types of businesses and industries with small businesses subject to the rule:

The businesses affected by proposed rule changes are primarily insurance companies, self-insured employers, service companies, and attorneys. Insurers and self-insured employers are not small businesses as defined in ORS 183.310. Approximately five service companies are small businesses. Approximately 200 attorneys represent the interests of workers, and most of these attorneys work for firms that are small businesses.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

Service companies process claims on behalf of insurers and self-insured employers. Therefore, the fiscal impacts described under "Statement of Cost of Compliance * * * The Public" above are relevant, including the provision that the agency may assess civil penalties against service companies for claims processing performance deficiencies revealed in annual audits. The agency projects no cost increases for reporting, recordkeeping, administrative activities, or professional services costs for attorneys who represent workers or their beneficiaries or estates.

c. Equipment, supplies, labor and increased administration required for compliance:

Service companies process claims on behalf of insurers and self-insured employers. Therefore, the fiscal impacts described under "Statement of Cost of Compliance * * * The Public" above are relevant, including requirements for issuance of forms and notices to the estates or beneficiaries of deceased workers, closing claims that were reopened for vocational training, and payment for interpreter services for certain depositions. The agency projects no cost increases for equipment, supplies, labor, or increased administration for attorneys who represent workers or their beneficiaries or estates.

How were small businesses involved in the development of this rule?

The agency notified more than 3,000 people about the rulemaking advisory committee meeting, including representatives of small businesses. The committee meeting of July 14, 2015, included representatives of small businesses.

Administrative Rule Advisory Committee consulted?: Yes

If not, why?:

09-28-2015 Close of Business	Fred Bruyns	fred.h.bruyns@oregon.gov
Last Day (m/d/yyyy) and Time for public comment	Printed Name	Email Address

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

Claim Closure and Reconsideration Oregon Administrative Rules Chapter 436, Division 030

Proposed

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NOTE: New text is underlined. Deletions have a ~~strike-through~~ style.

HISTORY LINES: These rules include only the most recent "History" lines. The last history line below each rule shows when the rule was last revised and its effective date. To obtain a comprehensive history for OAR chapter 436, please call the Workers' Compensation Division, 503-947-7627, or visit the division's website: **http://wcd.oregon.gov/policy/rules/history.html**.

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OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 030

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.

Statutory authority: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Statutes 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

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.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.206, 656.210, 656.212, 656.262, 656.268, 656.273, 656.325
Hist: Amended 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06
Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010

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.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.005, 656.206, 656.210, 656.212, 656.214, 656.262, 656.268, 656.273, 656.278, 656.325, 656.726
Hist: Amended 11/17/11 as WCD Admin. Order 11-058, eff. 1/1/12
Amended 2/12/15 as WCD Admin. Order 15-057, eff. 3/1/15

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<u>, estate, or beneficiary</u> 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 Or Laws, Ch. 144~~Enrolled SB 371~~), 656.726
Hist: Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010
Amended 1/29/15 as Admin. Order 15-052, eff. 3/1/15
Amended 5/21/15 as Admin. Order 15-059, eff. 5/21/15 (Temp)

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.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.268, 656.726, 656,740
Hist: Amended 11/1/07 as WCD Admin. Order 07-059, eff. 1/2/08
Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010

436-030-0015 Insurer Responsibility

(1) When an insurer issues a Notice of Closure (Form 440-1644, 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 440-2807) upon which the Notice is based, a completed "Insurer Notice of Closure Summary" (Form 440-1503) 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 ~~that have been accepted~~, 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,~~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."

(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 Or Laws, Ch. 144~~Enrolled SB 371~~), 656.331, 656.726
Hist: Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010
Amended 5/21/15 as Admin. Order 15-059, eff. 5/21/15 (Temp)

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.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.268, 656.319, 656.726, 656.745,
Hist: Amended 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04
Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010

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 440-2807 (Form 2807), as described by bulletin of the director.

(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:

(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 ~~worker's~~ 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 440-1644) 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.

<u>(9) If the worker is deceased at the time the Notice of Closure is issued:</u>

<u>(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.</u>

(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~~9~~) The worker's copy of the Notice of Closure must be mailed by both regular mail and certified mail return receipt requested.

(11~~0~~) An insurer may use electronically produced Notice of Closure forms if consistent with the form and format prescribed by the director.

(12~~1~~) 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~~2~~) 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~~3~~) Under ORS 656.268(10), if~~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 ~~a new Notice of Closure must be issued~~ 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.

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

(15~~4~~) 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 440-1502 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 Or Laws, Ch. 144~~Enrolled SB 371~~), 656.726, 656.745
Hist: Amended 1/29/15 as Admin. Order 15-052, eff. 3/1/15
Amended 5/21/15 as Admin. Order 15-059, eff. 5/21/15 (Temp)

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 440-1644c (Form 1644c) must be used and, to rescind a Notice of Closure, a Form 440-1644r (Form 1644r) must be used. An insurer may rescind and reissue a Notice of Closure by using a Form 440-1644 (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~~9~~).

(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 ~~G~~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 ~~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.

(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 ~~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.

Statutory authority: ORS 656.268, ORS 656.726~~, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313~~
Statutes implemented: ORS 656.210, ~~ORS~~ 656.212, ~~ORS~~ 656.214, ~~ORS~~ 656.268 (2015 Or Laws, Ch. 144~~2015 Enrolled SB 371~~), ~~ORS~~ 656.270, ~~ORS~~ 656.726, ~~ORS~~ 656.745~~,~~
~~1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313~~
Hist: Amended 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06
Amended 5/21/15 as Admin. Order 15-059, eff. 5/21/15 (Temp)

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.

Statutory authority: ORS 656.262, 656.268, 656.726
Statutes implemented: ORS 656.268, 656.726
Hist: Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010
Amended 1/29/15 as Admin. Order 15-052, eff. 3/1/15

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.

Statutory authority: ORS 656.268, ORS 656.726
Statutes implemented: ORS 656.268
Hist: Amended 11/1/07 as WCD Admin. Order 07-059, eff. 1/2/08
Amended 1/29/15 as Admin. Order 15-052, eff. 3/1/15

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.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.005, 656.160, ORS 656.210, 656.212, 656.236, 656.245, 656. 262, 656.268, 656.726
Hist: Amended 10/26/04 as WCD Admin. Order 04-062, eff. 1/1/05
Amended 11/17/11 as WCD Admin. Order 11-058, eff. 1/1/12

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.

Statutory authority: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Statutes 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

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.

Statutory authority: 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

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).

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.206, 656.214, 656.268, 656.283, 656.319, 656.325, 656.331, 656.726
Hist: Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010
Amended 1/29/15 as Admin. Order 15-052, eff. 3/1/15

436-030-0066 Review of Prior Permanent Partial Disability Awards

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:

(1) Requests for review and adjustment must be made in writing to the Workers' Compensation Division.

(2) 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.

(3) 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.

(4) 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.

Statutory authority: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Statutes 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

436-030-0115 Reconsideration of Notices of Closure

(1) A worker, ~~or~~ 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~~2~~) 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~~3~~) 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~~4~~) 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, ~~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.

(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~~5~~) 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 656.218, 656.268 (2015 Or Laws, Ch. 144 ~~Enrolled SB 371~~)
Hist: Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010
Amended 5/21/15 as Admin. Order 15-059, eff. 5/21/15 (Temp)

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 and the name of the requester's attorney, if any;

(8~~7~~) Any special language needs;

(9~~8~~) Whether there is disagreement with the specific impairment findings used to determine permanent disability at the time of claim closure;

(10~~9~~) Any information and documentation deemed necessary to correct or clarify any part of the claim record believed to be erroneous; and

(11~~0~~) 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~~, and 1999 OR Laws Chapter 313~~
Statutes implemented: ORS 656.268 (2015 Or Laws, Ch. 144~~Enrolled SB 371), and 1999 OR Laws Chapter 313~~
Hist: Amended 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04
Amended 5/21/15 as Admin. Order 15-059, eff. 5/21/15 (Temp)

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~~ the director and the worker or the worker's attorney~~, in chronological order by document date, all documents pertaining to the claim ~~which include~~including, but ~~are~~ 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~~is~~ 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 Or Laws, Ch. 144 ~~Enrolled SB 371~~)
Hist: Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010
Amended 1/29/15 as Admin. Order 15-052, eff. 3/1/15
Amended 5/21/15 as Admin. Order 15-059, eff. 5/21/15 (Temp)

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 ~~C~~claim ~~D~~disposition ~~A~~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 Or Laws, Ch. 144 ~~Enrolled SB 371) [OL 2011, ch. 99]~~
Hist: Amended 11/17/11 as WCD Admin. Order 11-058, eff. 1/1/12
Amended 5/21/15 as Admin. Order 15-059, eff. 5/21/15 (Temp)

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.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.268
Hist: Amended 11/1/07 as WCD Admin. Order 07-059, eff. 1/2/08
Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010

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 paid under OAR 436-009-0015, 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.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.268
Hist: Amended 11/17/11 as WCD Admin. Order 11-058, eff. 1/1/12
Amended 1/29/15 as Admin. Order 15-052, eff. 3/1/15

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.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.268 (§7, ch. 252, OL 2007)
Hist: Amended 11/1/07 as WCD Admin. Order 07-059, eff. 1/2/08

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.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.268
Hist: Amended 11/1/07 as WCD Admin. Order 07-059, eff. 1/2/08
Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010

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.

Statutory authority: ORS 656.268, ORS 656.726, and 1999 OR Laws Chapter 313
Statutes 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

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.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.268, 656.726, 656.745
Hist: Amended 12/5/05 as WCD Admin. Order 105-073 eff. 1/1/07
Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010

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Claims Administration
Oregon Administrative Rules
Chapter 436, Division 060

Proposed

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NOTE: Revisions are marked as follows:

Deleted text has a "strike-through" style, as in ~~Deleted~~
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HISTORY LINES: These rules include only the most recent "History" lines. A rule's history line shows when the rule was last revised and its effective date. To obtain a "Chapter 436 revision history index," please call the Workers' Compensation Division, (503) 947-7627, or visit the division's Web site: **http://wcd.oregon.gov/policy/rules/history.html**

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 060

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).

Statutory authority: ORS 656.210(2), 656.262(11), 656.264, 656.265(6), 656.325, 656.331, 656.704, and 656.726(4)
Statutes 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

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.

Statutory authority: ORS 656.262(11), 656.447, 656.704, 656.726(4), and 656.745
Statutes 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

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.

Statutory authority: 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)
Statutes implemented: ORS 656.704 and 656.726(4)
Hist: Amended 10/26/04 as WCD Admin. Order 04-064, eff. 1/1/05
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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, ~~which~~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~~ for the matter~~, unless the context requires otherwise.

(5) "Disposition" or "claim disposition" means the written agreement ~~as provided in~~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 ~~as defined in~~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," ~~as defined~~ 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 ~~prior to~~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 ~~which has been~~ 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.

(1~~4~~5) "Suspension of compensation" means:

(a) No temporary disability, permanent total disability, or medical and related service benefits ~~shall~~will accrue or be payable during the period of suspension; and

(b) Vocational assistance and payment of permanent partial disability benefits ~~shall~~will be stayed during the period of suspension.

~~(15) "Third party administrator" is the contracted agent for an insurer, as defined by these rules, authorized to process claims and make payment of compensation on behalf of the insurer.~~

(16) "Written" and its variations mean that which is expressed in writing, including electronic transmission.

Statutory authority: ORS 656.704 and 656.726(4)
Statutes implemented: ORS 656.704 and 656.726(4)
Hist: Amended 10/26/04 as WCD Admin. Order 04-064, eff. 1/1/05
Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09

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.

Statutory authority: ORS 656.704 and 656.726(4)
Statutes implemented: ORS 656.704 and 656.726(4)
Hist: Amended 10/2/02 as WCD Admin. Order 02-059, eff. 11/1/02

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.

Statutory authority: ORS 656.704, 656.726(4), and 656.745
Statutes implemented: ORS 656.245, 656.260, 656.704, 656.726(4), and 656.740(1)
Hist: Amended 11/1/07 as WCD Admin. Order 07-064, eff. 1/1/08
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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 ~~third-party administrators~~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 ~~third-party claims administrators~~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.

Statutory authority: ORS 192.502, 656.704 and 656.726(4)
Statutes implemented: ORS 656.704 and 656.726(4)
Hist: Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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 440-801 (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 440-827 (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 ~~third party administrator~~service company, if any, must be identified on all insurer generated workers' compensation forms, including insurer name, ~~third party administrator~~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 440-1502 (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 440-1503 (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 ~~third party administrators~~ 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.

Statutory authority: ORS 656.262, 656.264, 656.265(6), 656.704, 656.726(4) and 656.745
Statutes implemented: ORS 656.210, 656.262, 656.264, 656.265, 656.704, and 656.726(4)
Hist: Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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) A~~ a~~ddress all future notices and correspondence to the worker's estate or qualified beneficiaries~~.~~;

(~~2~~b) ~~If a worker is deceased, regardless of the cause of death, an insurer must still p~~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~~.~~; 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.

(~~3~~2) Other notices required under this chapter intended for the worker are not required when the worker is deceased.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.262, 656.264, 656.268
Hist: Adopted 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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 ~~third party administrator~~service company must provide the pamphlet, "What Happens if I'm Hurt on the Job?," Form 440-1138 (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 440-3283 (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 440-3058 (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, ~~third party administrators~~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.

Statutory authority: ORS 656.331, 656.704, 656.726(4), and 656.745
Statutes implemented: ORS 656.331, 656.704, and 656.726(4)
Hist: Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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 ~~third party administrator~~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.

Statutory authority: ORS 656.360, 656.362, 656.704, 656.726(4), and 656.745
Statutes implemented: ORS 656.704 and 656.726(4)
Hist: Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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.

Statutory authority.: ORS 656.268, 656.726
Stats. Implemented: ORS 656.210, 656.212, 656.214, 656.262, 656.268, 656. 273, 656.277, 656.745, and 656.726
Hist: Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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.

Statutory authority: ORS 656.210, 656.212, 656.704, and 656.726(4)
Statutes implemented: ORS 656.210, 656.212
Hist: Amended 10/26/04 as WCD Admin. Order 04-064, eff. 1/1/05

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.

Statutory authority: ORS 656.210(2), 656.245, 656.262, 656.307(1)(c), 656.704, and 656.726(4)
Statutes implemented: ORS 656.210, 656.212, 656.262 (Oregon Laws 2009, ch. 526), 656.307, 656.704, 656.726(4)
Hist: Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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.

Statutory authority: ORS 656.210(2), 656.704, and 656.726(4)
Statutes implemented: ORS 656.210, 656.704, 656.726(4)
Hist: Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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.

Statutory authority: ORS 656.212, 656.704, and 656.726(4)
Statutes implemented: ORS 656.212, 656.268, 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

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 ~~third party administrator~~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.

Statutory authority: ORS 656.210, 656.704, and 656.726(4)
Statutes implemented: ORS 656.210, 656.325(5), 656.704, 656.726(4)
Hist: Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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.

Statutory authority: ORS 656.268(10), 656.704, and 656.726(4)
Statutes 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

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.

Statutory authority: ORS 656.160, 656.704, and 656.726(4)
Statutes 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

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.

Statutory authority: ORS 656.262(5), 656.704, 656.726(4), and 656.745
Statutes 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

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.

Statutory authority: ORS 656.704 and 656.726(4)
Statutes implemented: ORS 656.230, 656.704, and 656.726(4)
Hist: Amended 11/1/07 as WCD Admin. Order 07-064, eff. 1/1/08
Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09

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.

Statutory authority: ORS 656.325, 656.704, and 656.726(4)
Statutes 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
Amended 3/1/11 as Admin. Order 11-052, eff. 4/1/11

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.

Statutory authority: ORS 656.325, 656.704, and 656.726(4)
Statutes implemented: ORS 656.325, 656.704, and 656.726(4)
Hist: Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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.

Statutory authority: ORS 656.704 and 656.726(4)
Statutes implemented: ORS 656.262 (Oregon Laws 2009, ch. 526), 656.704, 656.726(4)
Hist: Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.206)
Hist: Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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.

Statutory authority: ORS 656.704 and 656.726(4)
Statutes implemented: ORS 656.262 (Oregon Laws 2009, ch. 526), 656.325, 656.704, and 656.726(4)
Hist: Amended 11/1/07 as WCD Admin. Order 07-064, eff. 1/1/08
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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).

Statutory authority: ORS 656.704 and 656.726(4)
Statutes implemented: ORS 656.325(1), 656.704, and 656.726(4)
Hist: Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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 ~~falling~~ due on a weekend or legal holiday under ORS 187.010 and 187.020 may be paid on the last working day ~~prior to~~before or the first working day ~~following~~after the weekend or legal holiday. Subsequent payments may revert back to the payment schedule ~~prior to~~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 ~~shall be~~is a legal holiday. Each time a holiday falls on Saturday, the preceding Friday ~~shall be~~is a legal holiday.

(l) Additional legal holidays ~~shall~~ 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 ~~ORS~~ 656.596(2), ~~shall~~will not be deemed untimely ~~provided~~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 ~~has been made~~ 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, ~~provided~~if the attending physician or authorized nurse practitioner has authorized temporary disability. Temporary disability accrued ~~prior to~~before the date of the employer's notice or knowledge of the claim ~~shall~~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 ~~claim has~~ previously ~~been~~ 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, ~~which~~that orders payment of temporary disability. If the insurer has appealed a reconsideration order ~~has been appealed by the insurer~~, the appeal stays payment of temporary disability benefits except those ~~which~~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 ~~as provided in~~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 ~~which~~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, ~~which~~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 s~~S~~ubsequent payments of permanent disability and fatal benefits ~~are made~~ in monthly sequence. The insurer may adjust monthly payment dates, but must inform the beneficiary ~~prior to~~before making the adjustment. No payment period ~~shall~~will exceed one month without the division 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 ~~for which~~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.

Statutory authority: ORS 656.704 and 656.726(4)
Statutes 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 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.262(4) and 84.013
Hist: Adopted 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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 ~~as provided in~~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~~ment of~~ a civil penalty ~~may occur~~ 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~~failure to~~ provide copies of the response to the worker or attorney timely~~ may result in the assessment of a $50.00 civil penalty under OAR 436-060-0200~~.

(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~~ shall be considered~~ unreasonable, unless the worker has provided insufficient information to assess a penalty. In such cases, the director may assess a civil penalty ~~may be assessed~~ 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 ~~prior to~~before the director issu~~ing~~es an order under this section, and the director is made aware of the proceeding, jurisdiction over the penalty proceeding before the director ~~shall~~will immediately rest with the Hearings Division and the director will~~result in~~ refer~~ral of~~ 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 ~~which~~that becomes final, the director's penalty~~ of the director~~ 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 ~~Failure to~~ pay penalties in a timely manner the insurer will be subject ~~the insurer~~ 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 ~~described in~~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 ~~must be submitted~~ 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 ~~Failure to~~ pay penalties in a timely manner the insurer will be subject ~~the insurer~~ to civil penalties under OAR 436-060-0200.

(11) Any other agreements between the parties to pay a penalty or attorney fee without ~~benefit of~~ a stipulation approved by the division will not be acknowledged as a violation as it applies to the matrix attached to these rules.

Statutory authority: ORS 656.262(11), 656.704, 656.726(4), and 656.745
Statutes implemented: ORS 656.262(11), 656.704, and 656.726(4)
Hist: Amended 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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.

Statutory authority: ORS 656.704 and 656.726(4)
Statutes implemented: ORS 656.704 and 656.726(4)
Hist: Amended 10/2/02 as WCD Admin. Order 02-059, eff. 11/1/02

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.

Statutory authority: ORS 656.704 and 656.726(4)
Statutes 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

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.

Statutory authority: ORS 656.307, 656.704, 656.726(4), and 656.745
Statutes implemented: ORS 656.307, 656.308, 656.704, and 656.726(4)
Hist: Amended 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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.

Statutory authority: ORS 656.704 and 656.726(4)
Statutes 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

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.

Statutory authority: ORS 656.704, 656.726(4), and 656.745
Statutes implemented: ORS 656.704 and 656.726(4)
Hist: Amended 10/26/04 as WCD Admin. Order 04-064, eff. 1/1/05
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

436-060-0200 Assessment of Civil Penalties

(1) The director through the division and under ORS 656.745 ~~shall~~will assess a civil penalty against an employer or insurer ~~who~~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 ~~so~~ 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 ~~who fails to~~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 a~~A~~n employer or insurer ~~failing to~~that does not 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.~~ 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 ~~who~~that willfully violates OAR 436-060-0160 ~~shall~~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, ~~or~~ insurer, or service company ~~who~~that 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.

(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 ~~shall~~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.

Statutory authority.: ORS 656.704 and 656.726(4)
Statutes 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 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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.

Statutory authority.: ORS 656.726(4)
Statutes implemented: 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 ~~third party administrator~~service company. The director will reimburse the insurer, in care of a ~~third party administrator~~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 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.206, 656.605
Hist: Filed 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06
Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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%

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Retroactive Program
Oregon Administrative Rules
Chapter 436, Division 075

Proposed

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NOTE: Revisions are marked as follows:

Deleted text has a "strike-through" style, as in ~~Deleted~~
Added text is underlined, as in Added

HISTORY LINES: These rules include only the most recent "History" lines. A rule's history line shows when the rule was last revised and its effective date. To obtain a "Chapter 436 revision history index," please call the Workers' Compensation Division, (503) 947-7627, or visit the division's website: http://wcd.oregon.gov/policy/rules/rules.html#fullset

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OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 075

436-075-0001 Authority for Rules

These rules are promulgated under the director's authority ~~contained~~ in ORS 656.726 and 656.506.

Statutory authority: ORS 656.506 and 656.726
Statutes implemented: ORS 656.506
Hist: Filed 12-22-89 as WCD Admin. Order 6-1989, eff. 1-1-1990

436-075-0002 Purpose

The purpose of these rules is to establish guidelines for administering disbursements made from the Retroactive Program.

Statutory authority: ORS 656.506
Statutes implemented: ORS 656.506
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98

436-075-0003 Applicability of Rules

(1) These rules are effective January 1, ~~1998~~2016, and ~~shall~~ apply to all requests for reimbursement from the Retroactive Program involving benefits payable ~~pursuant to~~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 ~~prior to~~before April 1, 1974.

(2)~~ Applicable to this chapter, t~~The director may waive procedural rules as justice requires, unless otherwise obligated by statute~~, in the director's discretion waive any procedural rules as justice so requires~~.

Statutory authority: ORS 656.209, 656.206, 656.208, 656.210, 656.236, 656.289 and 656.506
Statutes implemented: ORS 656.204, 656.206, 656.208, 656.210, 656.276, 656.289 and 656.506
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98

436-075-0005 Definitions

Except where the context requires otherwise, these rules are governed by the following definitions:

(1) "~~Average Weekly Wage" is that wage defined in ORS 656.005~~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) "Compliance" means the Compliance Section of the Workers' Compensation Division of the Department of Consumer and Business Services.~~

(4~~3~~) "Department" means the Department of Consumer and Business Services.

(~~5~~4) "Director" means the director of the Department of Consumer and Business Services or the director's designee.

(~~6~~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.

(~~7~~6) "~~Expiration of Benefits" means the end of entitlement to a benefit because of limits set forth in the statute in effect at the time of the worker's injury.~~

~~(8) "~~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 ~~who~~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.

(~~9~~8) "Retroactive Program benefit" means that additional benefit paid to eligible claimants or beneficiaries to bring their benefits to a more current level.

(~~10~~9) "Social Security ~~O~~offset" means a reduction of permanent total disability benefits or fatal benefits based ~~up~~on the amount of federal social security disability benefits received by a worker or surviving spouse.

(1~~1~~0) "Spouse" means the ~~husband or wife~~spouse of a worker. This definition ~~also~~ includes cohabitants ~~as defined in~~under ORS 656.226.

(1~~2~~1) "Statutory ~~B~~benefit" means any benefit payable to or on behalf of the injured worker ~~in accordance with~~under the law in effect at the time of the worker's injury, as modified by marital~~/~~ and dependency status changes.

(1~~3~~2) "Through" means inclusion of a specific date.

(1~~4~~3) "To" means until but not including a specific date.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.726
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98

436-075-0006 Administration of Rules

~~For the purpose of~~In administering these rules, orders of ~~Compliance~~the Performance Section are deemed orders of the director.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.726
Hist: Filed 12-22-89 as WCD Admin. Order 6-1989, eff. 1-1-90

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 ~~pursuant to~~under ORS 656.745 or 656.750 may request a hearing by the Hearings Division of the Workers' Compensation Board ~~in accordance with~~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 ~~up~~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 ~~as provided in~~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.

Statutory authority: ORS 656.740, 656.745, 656.750
Statutes implemented: ORS 656.704, OL 2005 ch 26, 656.740, 656.745, and 656.750
Hist: Amended 10/19/05 as WCD Admin. Order 05-065, eff. 1/2/06

436-075-0010 Criteria for Eligibility

(1) The department ~~shall~~will issue a bulletin to notify all insurers of changes in the Retroactive Program benefit levels whenever the director determines a change is necessary ~~as indicated in~~under ORS 656.506(7).

(2) Eligibility for Retroactive Program benefits ~~shall be~~is based ~~up~~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 ~~prior to~~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 ~~shall~~is not ~~be~~ eligible for Retroactive Program benefits if all issues except compensable medical services are disposed of ~~pursuant to~~under ORS 656.236 or settled ~~pursuant to~~under ORS 656.289 ~~prior to~~before becoming eligible under section (2) of this rule.

(4) Costs for claims of subject workers of a~~n~~ noncomplying employer ~~which is noncomplying as defined in~~under ORS 656.052 are not eligible for reimbursement from the program, but remain a cost recoverable from the employer ~~as provided by~~under ORS 656.054(3).

Statutory authority: ORS 656.506
Statutes implemented: ORS 656.236, 656.289 and 656.506
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98

436-075-0020 Death Benefit

(1) Death benefits ~~shall~~must be paid to eligible beneficiaries ~~pursuant to~~under ORS 656.204~~,~~ and the Retroactive Program benefit schedules.

(2) Burial benefits ~~shall~~must be paid ~~pursuant to~~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 ~~shall~~may request reimbursement only for the adjusted Retroactive Program benefit.

(4) Benefits payable for a partial month ~~shall~~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 ~~dependents shall~~beneficiaries must be paid to the date of any status change.

(6) Remarriage allowance ~~shall~~must be paid ~~pursuant to~~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.

Statutory authority: ORS 656.506
Statutes implemented: ORS 656.204
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98

436-075-0030 Permanent Total Disability Benefit

(1) Permanent total disability benefits ~~shall~~must be paid ~~in accordance with~~under ORS 656.206 and the benefit schedules ~~set forth~~ in the Retroactive Program bulletin.

(2) Benefit amounts payable for a partial month ~~shall~~must be calculated ~~as set forth in~~under 436-075-0020(4).

(3) Benefits for ~~dependents shall~~beneficiaries must be paid to the date of any status change.

(4) Any Social Security ~~O~~offset determined ~~pursuant to~~under ORS 656.209 ~~shall be~~must first be applied against the statutory portion of the permanent total disability benefit. Any amount of the ~~s~~Social ~~s~~Security offset that exceeds the statutory benefit ~~shall~~must be applied against the Retroactive Program benefit. The insurer ~~shall~~may request reimbursement only for that portion of the Retroactive Program benefit ~~which~~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.

Statutory authority: ORS 656.506
Statutes implemented: ORS 656.206 and 656.209
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98

436-075-0040 Death during Permanent Total Disability

(1) If the injured worker dies during the period of permanent total disability, death benefits ~~shall~~must be paid to eligible beneficiaries ~~pursuant to~~under ORS 656.208, ~~and ORS~~ 656.204, and the Retroactive Program benefit schedules.

(2) Permanent total disability benefits ~~shall~~must be paid to the date of death, at which time death benefits will ~~commence~~begin. Where death benefits are not due, permanent total disability benefits ~~shall~~must be paid through the date of death.

(3) The Social Security benefit for injuries occurring between July 1, 1973 and April 1, 1974 ~~will~~must be applied ~~as set forth in~~under OAR 436-075-0020 (3).

(4) Benefit amounts payable for a partial month ~~shall~~must be calculated ~~as set forth in~~under OAR 436-075-0020(4).

(5) Burial benefits ~~shall~~must be paid ~~in accordance with~~under ORS 656.208 (1), ~~and~~ 656.204 (1), and the Retroactive Program benefit schedules.~~; h~~ However, if the injury date is ~~prior to~~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.

Statutory authority: ORS 656.506
Statutes implemented: ORS 656.204 and 656.208
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98

436-075-0050 Temporary Total Disability

(1) Temporary total disability benefits ~~shall~~must be paid ~~in accordance with~~under ORS 656.210, OAR 436-060-0150, and the benefit schedules ~~set forth~~ in the Retroactive Program bulletin.

(2) ~~In no case shall t~~The computation of benefits under these rules and the Retroactive Program bulletin ~~cause a~~may not reduce~~tion in~~ temporary total disability benefits currently being paid.

Statutory authority: ORS 656.506
Statutes implemented: ORS 656.210
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98

436-075-0065 Dispositions

(1) ~~Any d~~Disposition of the claim by the parties ~~pursuant to~~under ORS 656.236, or settlement of the claim ~~pursuant to~~under ORS 656.289, is not eligible ~~to receive~~for reimbursement from the Retroactive Program unless made with the director's prior written approval ~~of the director~~.

(2) Requests for written approval of proposed dispositions ~~should~~must include:

(a) A copy of the proposed disposition ~~which~~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 ~~as~~ 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 ~~shall~~must submit dispositions to the division in the format prescribed by the director.

Statutory authority: ORS 656.506
Statutes implemented: ORS 656.236 and 656.289
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98

436-075-0070 Reimbursement

(1) Reimbursement from the Retroactive Program will be authorized by the ~~Compliance~~Performance Section on a quarterly basis.

(2) Requests for reimbursement must be mailed or delivered to ~~Compliance~~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 ~~Compliance~~the Performance Section more than 30 days after the end of the quarter will be ~~held over and~~ processed with the next quarterly disbursement.

(4) A separate request for reimbursement ~~shall~~must be submitted for each insurer and ~~shall~~ 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) ~~Compliance~~The Performance Section will not process any request ~~failing to~~that does not meet the requirements of section (4) or (5) of this rule~~,~~ until such requirements are met.

(7) The department ~~shall~~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) I~~n the event~~f a denied claim is found to be compensable by a ~~hearing referee~~n 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 ~~shall~~will receive reimbursement for Retroactive Program benefit payments required to be made while the claim was in an accepted status.

Statutory authority: ORS 656.506
Statutes implemented: ORS 656.506
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98

436-075-0090 Third Party Recovery

(1) In ~~the event of~~ a third party recovery, previously reimbursed Retroactive Program benefits are a portion of the paying agency's lien.

(2) Under ORS 656.593, w~~W~~hen the insurer learns of third party settlement negotiations on any claim for which it has received reimbursement from the Retroactive Program, the insurer ~~should~~must notify ~~Compliance~~the Performance Section ~~in accordance with the provisions set forth in ORS 656.593~~.

(3) Remittance on recovered Retroactive Program benefits ~~shall~~must be made to the department in the quarter following the recovery in amounts determined ~~in accordance with~~under ORS 656.591 and ~~ORS~~ 656.593.

Statutory authority: ORS 656.506
Statutes implemented: ORS 656.591 and 656.593
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98

436-075-0100 Assessment of Civil Penalties

~~Pursuant to~~Under ORS 656.745 the director may assess a civil penalty against an insurer for failure to comply with these rules. Penalty orders ~~shall~~will be issued ~~in accordance with~~under ORS 656.447 and 656.704 and are subject to review under OAR 436-075-0008.

Statutory authority: ORS 656.745
Statutes implemented: ORS 656.204, 656.726, 656.745 and 656.447
Hist: Amended 11-29-90 as WCD Admin. Order 23-1990, eff. 12-26-90

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Workers' Compensation Benefits Offset
Oregon Administrative Rules
Chapter 436, Division 100

Proposed

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NOTE: Revisions are marked as follows:
Deleted text has a "strike-through" style, as in ~~Deleted~~
Added text is underlined, as in Added

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OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 100

436-100-0001 Authority for Rules

(1) These rules are promulgated under the director's authority contained in ORS 656.726 and 656.727.

Statutory authority: ORS 656.209, ORS 656.726 and ORS 656.727
Statutes implemented: ORS 656.209
Hist: WCB 7-1987, f. 6-5-78, ef. 6-6-78
WCD 4-1983 (Admin) (Temp), f. & ef. 9-1-83;
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 ~~the administration of~~ offsetting permanent total disability benefits against social security disability benefits.

Statutory authority: ORS 656.209 and ORS 656.727
Statutes implemented: ORS 656.209
Hist: WCB 7-1987, f. 6-5-78, ef. 6-6-78
WCD 4-1983 (Admin) (Temp), f. & ef. 9-1-83;
WCD 2-1984 (Admin), f. & ef. 2-22-84

436-100-0003 Applicability of Rules

(1) These rules are effective January 1, ~~1998~~2016, to carry out the provisions of ORS 656.209 and ~~ORS~~ 656.727.

(2) These rules apply to:

(a) Those workers receiving awards for permanent total disability and ~~are~~ 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) ~~Applicable to this chapter, t~~The director may waive procedural rules as justice requires, unless otherwise obligated by statute~~, in the director's discretion waive any procedural rules as justice so requires~~.

Statutory authority: ORS 656.209 and ORS 656.727
Statutes implemented: ORS 656.209
Hist: WCB 7-1987, f. 6-5-78, ef. 6-6-78
WCD 4-1983 (Admin) (Temp), f. & ef. 9-1-83;
WCD 2-1984 (Admin), f. & ef. 2-22-84
Amended 12/4/97 as WCD Admin. Order 97-063, eff. 1/1/98

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~~ husband, wife~~spouse, child or dependent of a worker, who is entitled to receive payments under ORS 656.001 through ~~ORS~~ 656.794.

~~(3) "Compliance Section" means the Compliance Section of the Workers' Compensation Division.~~

(4~~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 ~~pursuant to~~under 42 USC 224(a) and Social Security Administration rules.

(7) "Offset" means a reduction of permanent total disability benefits based ~~up~~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.

(~~9~~10) "Permanent total disability benefits" means compensation to an injured worker awarded permanent total disability compensation under ORS 656.206.

(1~~0~~1) "Worker" means any worker receiving permanent total disability benefits.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.209
Hist: WCB 7-1987, f. 6-5-78, ef. 6-6-78
WCD 4-1983 (Admin) (Temp), f. & ef. 9-1-83;
WCD 2-1984 (Admin), f. & ef. 2-22-84
Amended 12/4/97 as WCD Admin. Order 97-063, eff. 1/1/98

436-100-0006 Administration of Rules

~~For the purpose of~~In administration of these rules, orders of the Workers' Compensation Division are deemed orders of the director.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.209 and ORS 656.726
Hist: WCB 7-1987, f. 6-5-78, ef. 6-6-78
WCD 4-1983 (Admin) (Temp), f. & ef. 9-1-83;
WCD 2-1984 (Admin), f. & ef. 2-22-84

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 ~~prior to~~before requesting a hearing.

(2) Any party aggrieved may request a hearing ~~pursuant to the provisions of~~under ORS 656.283.

Statutory authority: ORS 656.726 and ORS 656.727

Statutes implemented: ORS 656.209
Hist: WCB 7-1987, f. 6-5-78, ef. 6-6-78
WCD 4-1983 (Admin) (Temp), f. & ef. 9-1-83;
WCD 2-1984 (Admin), f. & ef. 2-22-84
Amended 12/4/97 as WCD Admin. Order 97-063, eff. 1/1/98

436-100-0010 Criteria for Eligibility

(1) Permanent total disability benefits ~~shall~~must be offset by the workers' social security disability benefits. However, the total combined benefit, permanent total disability benefits plus social security disability benefits, ~~shall~~must not be offset to an amount less than the greater of:

(a) The amount the worker would have received ~~pursuant to~~under ORS chapter 656; or

(b) The ~~f~~Federal Disability B~~b~~enefit ~~l~~Limitation.

(2) Permanent total disability benefits ~~shall~~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 ~~shall~~must be made by a paying agent only in an amount and as authorized by the director.

(4) Offset of permanent total disability benefits ~~shall~~will be authorized by the director only upon actual receipt of federal social security disability benefits by the injured worker.

Statutory authority: ORS 656.209 and ORS 656.727
Statutes implemented: ORS 656.209
Hist: WCB 7-1987, f. 6-5-78, ef. 6-6-78
WCD 4-1983 (Admin) (Temp), f. & ef. 9-1-83;
WCD 2-1984 (Admin), f. & ef. 2-22-84

436-100-0020 Requirements of Workers

(1) Workers entitled to receive permanent total disability benefits ~~shall~~must make application for federal social security disability benefits.

(2) Workers and eligible beneficiaries ~~shall~~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 ~~shall~~must notify the ~~Compliance~~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.

Statutory authority: ORS 656.209 and ORS 656.727
Statutes implemented: ORS 656.209 and ORS 656.727
Hist: WCB 7-1987, f. 6-5-78, ef. 6-6-78
WCD 4-1983 (Admin) (Temp), f. & ef. 9-1-83;
WCD 2-1984 (Admin), f. & ef. 2-22-84

436-100-0030 Authorization of Offset; Effective Date

(1) Authorization issued by the department ~~shall~~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 ~~shall~~will be entitled to social security disability offset only as authorized by the department.

(3) The department ~~shall~~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 ~~his/her~~the worker's beneficiaries receiving benefits for permanent total disability subject to offset, the paying agent ~~shall~~must notify the ~~Compliance~~Performance Section.

(5) The paying agent ~~will~~must, immediately upon the death of a worker, terminate payment of previously authorized permanent total disability benefits offset and ~~commence~~begin payment of other compensation due under ORS ~~C~~chapter 656, if any.

(6) The effective date of offset ~~will~~must be the effective date established in the authorization.

Statutory authority: ORS 656.209 and ORS 656.727
Statutes implemented: ORS 656.209 and ORS 656.727
Hist: WCB 7-1987, f. 6-5-78, ef. 6-6-78
WCD 4-1983 (Admin) (Temp), f. & ef. 9-1-83;
WCD 2-1984 (Admin), f. & ef. 2-22-84

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 ~~shall~~ 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 ~~shall be made~~ upon ~~him~~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 ~~O~~order of ~~S~~suspension of benefits ~~shall~~ will continue in force from the date issued until the date the worker actually complies with these rules.

(4) No compensation ~~shall~~will become due or ~~shall~~ be payable during a period of suspension of benefits.

Statutory authority: ORS 656.209 and ORS 656.727
Statutes implemented: ORS 656.209 and ORS 656.727
Hist: WCB 7-1987, f. 6-5-78, ef. 6-6-78
WCD 4-1983 (Admin) (Temp), f. & ef. 9-1-83;
WCD 2-1984 (Admin), f. & ef. 2-22-84

Exhibit "2"

BRUYNS Fred H * DCBS

From: Lisa Wilch <liswil@saif.com>
Sent: Wednesday, September 16, 2015 9:49 AM
To: BRUYNS Fred H * DCBS
Cc: Melinda Patton; Dan Schmelling; OSTRAND-PONSIOEN Cathy * DCBS
Subject: RE: 436-030-0165 (10)

Definitely.

Have a good day!

Lisa

From: BRUYNS Fred H * DCBS [mailto:Fred.H.Bruyns@oregon.gov]
Sent: Wednesday, September 16, 2015 9:44 AM
To: Lisa Wilch <liswil@saif.com>
Cc: Melinda Patton <MELPAT@saif.com>; Dan Schmelling <dansch@saif.com>; OSTRAND-PONSIOEN Cathy * DCBS <Cathy.Ostrand-Ponsioen@oregon.gov>
Subject: RE: 436-030-0165 (10)

Hi Lisa –

Thank you! Because division 030 is open currently, may I enter your email as testimony?

Fred Bruyns, policy analyst/rules coordinator
Department of Consumer and Business Services
Workers' Compensation Division
503-947-7717; fax 503-947-7514
Email: fred.h.bruyns@oregon.gov

From: Lisa Wilch [mailto:liswil@saif.com]
Sent: Wednesday, September 16, 2015 9:39 AM
To: BRUYNS Fred H * DCBS
Cc: Melinda Patton; Dan Schmelling
Subject: 436-030-0165 (10)

Fred – I was looking up a rule this morning with respect to reimbursement of arbiter related expenses. It appears one of the citations in this rule no longer exists. The rules now jump from 436-009-0010 to 436-009-0018.

(10) All costs related to record review, examinations, tests, and reports of the medical arbiter must be paid under **OAR 436-009-0015**, 436-009-0040, and 436-009-0060.

Could you save it for the next Division 30 update?

Lisa Wilch, Claims Director
SAIF Corporation | Claims Division
400 High Street SE | Salem, Oregon 97312 | P: 503.315.3502

P: 800.285.8525 | F: 503.945.3502 | liswil@saif.com

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Exhibit
"3"

BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON

PUBLIC RULEMAKING HEARING

In the Matter of the Amendment of OAR: 436-030, Claim Closure and Reconsideration 436-060, Claims Administration 436-075, Retroactive Program 436-100, Workers' Compensation Benefits Offset	)))))	TRANSCRIPT OF TESTIMONY

The proposed amendment to the rules was announced in the Secretary of State's Oregon Bulletin dated September, 2015. On Sept. 22, 2015, a public rulemaking hearing was held as announced at 11 a.m. in Room F of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers' Compensation Division, acted as hearing officer. The record will be held open for written comment through Sept. 28, 2015.

TRANSCRIPT OF PROCEEDINGS

Today is Tuesday, the 22nd of September, 2015. It is 11:30 a.m. My name is Fred Bruyns. I'm the hearing officer for a public rulemaking hearing scheduled for this date.

Let the record show that the Oregon Workers' Compensation Division held a public rulemaking hearing at 11 a.m. on this date. The proposed rules filed with the Secretary of State on Aug. 11, 2015, are in chapter 436 of the Oregon Administrative Rules, division 030, Claim Closure and Reconsideration, division 060, Claims Administration, division 075, Retroactive Program, and division 100, Workers' Compensation Benefits Offset.

No one from the public attended or testified.

Transcribed from a digital audio recording by Fred Bruyns, Sept. 22, 2015.