

Agenda

Rulemaking Advisory Committee

Workers' Compensation Division Rules
OAR chapter 436, division 060, Claims Administration
Rule 0025, Rate Of Temporary Disability Compensation

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	July 18, 2016, 2 p.m. to 5 p.m. Room 260, Labor and Industries Building, Salem, Oregon
Facilitator:	Fred Bruyns, Workers' Compensation Division
2 p.m. to 2:15	Welcome and introductions; meeting objectives
2:15 to 3:30	Discussion: Draft OAR 436-060-0025
3:30 to 3:45	Break
3:45 to 4:45	Discussion continued; additional input about draft rules
4:45 to 4:55	Summing up – next steps Thank you!

Attached: [Issues document – 436-060-0025](#)

[Draft rules](#)

ISSUE #20.5 – OAR 436-060-0025 - “Rate of Temporary Disability Compensation”

Issue: Should this rule be completely rewritten to eliminate the current approach to determining the worker’s average weekly wage (AWW) and replace it with a simpler method (52-week gross earning average or some other option) that can be applied in almost all situations?

Background: The division has been considering how the Division 060 rules could better facilitate improved industry accuracy in determining workers’ AWW (the basis for calculating temporary disability benefits), due to consistently unsatisfactory performance in this claims processing area. In reviewing nearly 23,000 time loss payments during the recently completed Pre-Closure Accuracy (PCA) audit, WCD found an overall accuracy of 63.2%. Almost one in four (23.3%) of AWW calculations were inaccurate, the most common reason for 70.7% of payment inaccuracies. Inaccurate AWWs were the sole cause for 61.1% of inaccurate payments. This particular error tends to cause all claim payments to be inaccurate, while other errors tend to affect just one or two payments. Eliminating AWW calculation errors would have raised the overall payment accuracy in the PCA audit to nearly 87%.

Regulated parties and their claims processors often, and understandably, complain about the length and complexity of the AWW rule with its many permutations intended to address particular work/schedule/pay variables. At the same time, as the nature of employment situations continuously evolve, the industry also requests this rule’s expansion to address additional work and wage scenarios. Interestingly, the most common error identified in the PCA audit in calculating the AWW (25.3%) was due to processors averaging gross earnings when the current rule required that they average hours worked and use the at-injury pay rate. This finding likely reflects the existing rule’s complexity and shortcomings. In addition to the general method for calculating the AWW, 19 of the 31 topics addressed in the current rule attempt to provide direction on handling specific situations and what to include/exclude in the worker’s wage. This fact, combined with the audit findings, also raise the questionable value of further “clarifying” revisions and point to the need for a simpler, “common sense” alternative.

WCD met with a focus group of insurer, self-insured employer, and service company representatives in three meetings in late 2014. A recurring theme among attendees was the need for an AWW calculation method that is “simpler,” “cleaner, easier,” “increases consistency and predictability,” and can be more “easily explained.” The division has similar interests.

WCD is offering the following proposal both for consideration and as the basis for the advisory committees’ discussions of other possible approaches. It is one option, but WCD wants to hear about other alternatives or variations.

Initial Proposal:

- Eliminate all rules addressing various wage scenarios in 060-0025.

- Define “wage at injury” with an AWW wage calculation more easily applied in the majority of cases that incorporates situation-specific differences and considers “equity” for both workers and employers.
- Specifically, average gross earnings for the 52 weeks prior to the injury, considering extended gaps. Salaried workers with no pay variations could be the exception.
- Adapt North Carolina’s approach, determining earnings based on the length of the worker’s employment, while considering the fairness/equity for new employees and mitigating circumstances or factors.
- Define gross earnings.
- Define extended gaps, to facilitate consistency in AWW calculations.
- Defer changing Oregon’s “5-day worker” methodology (re: how to treat scheduled days off, weekends, etc.) to a “7-day worker” basis until after the new AWW calculation method has been implemented and evaluated.

Pros:

- Simplifies the calculation of AWW for the majority of workers, likely improving accuracy.
- Recognizes evolving employment and pay practices.
- Considers more than just the job at injury.
- Recognizes there often isn’t an initial or clear “intent of wage earning agreement.”
- Addresses industry input that averaging gross earnings would be easier and faster, and increase consistency and predictability.
- For most workers the AWW calculation should be close to what it would be under the current method, and the method would be similar to the approach used for unemployment benefit calculations.
- Provides direction for resolving situations re: very short employment or where the method results in an “unfair” calculation.
- Defining extended gaps will increase clarity and consistency, thereby reducing any related litigation.
- Eliminates the need for continuing rule amendments to address specific situations and evolving employment practices.
- The effects of averaging gross earnings on AWW accuracy and consistency will be more easily evaluated as a separate variable (from the other factor of 5-day vs. 7-day worker).

Cons:

- It may be difficult to align on an “extended gaps” standard and whether the reason(s) for the gap(s) should be considered. Also, with the averaging method applied to all workers, the number of cases with gaps will increase to some degree.
- The timing of pay raises in the 52-week, pre-injury period will likely result in AWW calculations that are slightly lower than currently, where weekly hours are averaged using the date-of-injury wage. This might warrant application of the fourth calculation method for an amount approximating what the worker would be earning but for the injury, and may result in a wage dispute or litigation.
- Rules will still need to address certain aspects of what is included in gross earnings.
- Some industry representatives may conclude that the potential benefits of averaging gross earnings will be lessened, absent a simultaneous change to a 7-day worker standard.

Separately, if 060-0025 is revised to implement a different methodology for determining the AWW used in calculating the temporary disability rate, Division 120 vocational services rules may need to be reviewed for possible impact on rules establishing the adjusted weekly wages for determining “suitable wage.”

Fiscal Impacts, including cost of compliance for small business:

- We anticipate that after the initial transition this will lower administrative costs associated with claims processing.
- Some workers may see slightly lower benefits, but on average we do not expect benefit rates to be significantly effected.

Recommendations:

- (1) Split off wages in lieu of comp and supplementing TD into their own paragraph with other wage continuation language.
- (1) Clarify rate of wage continuation
- (3)No changes
- (3)(a) Keep monthly divided by 4.35,
 - Seasonal workers are now included under gross earnings.
 - Should seasonally employed workers be based on season earnings only, like Supreme Court decision, or only depending on employment history?
 - Add statement for workers with annual salary: “Yearly wages are divided by 12 to convert to monthly; monthly wages are divided by 4.35 to establish weekly wage.”
 - Add similar language for other time periods: convert to monthly, divide by 4.35.
- (3)(b): Remove, but discuss union hall call boards further at future stakeholder meeting.
- (4) Move to end of -0025. Add a clause that parties must attempt to negotiate a fair wage before going to hearing.

- (5)(a) Delete this paragraph – all workers fall under this method, except those listed later, like monthly/yearly salary, etc.
- (5)(a)(A) For workers employed more than four weeks, insurers must average gross earnings over the length of employment up to 52 weeks prior to the injury.
 - Keep references to supplemental disability.
 - If employed less than four weeks, use intent of earning agreement.
- (5)(a)(B) If change in earning agreement due to change of job duties, hours worked, or another factor besides just a change in pay rate, insurer must average earnings under the most recent earning agreement.
 - If employed less than four weeks under that agreement, use intent of current earning agreement.
- (5)(a)(C) Where there are gaps in earnings greater than one week that are not an expectation of the employment, insurers shall not include those gaps in the average.
- (5)(b) Delete - no exception for temp workers
- (5)(c) Change “salary” to “wages.”
- (5)(d) Move to 0030,
- (5)(e) Delete – tips are “wages” (by statute) so are included under basic average calc..
- (5)(f) Delete – o.t. is “wages” so is included under basic average calc. Always included.
- (5)(g) Delete – bonus pay should be considered “wages” when it is an expected part of the earnings agreement, this is consistent with employment department standards.
- (5)(h) Delete – incentive pay is based on performance, and is considered part of wages.
- (5)(i) Keep - Move near monthly/yearly salary method, clarify how assumed wage may be obtained.
- (5)(j) Delete – Commission is included under basic method.
- (5)(k) Keep – Combine all assumed wage rules into one.
- (5)(l) Delete – Annual salary covered under (3).
- (5)(m) Delete – Irregular cyclic included in basic calculation., but move daily wage determination to (3).

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION



Claims Administration
Oregon Administrative Rules
Chapter 436, Division 060

DRAFT Proposed {Effective Date}

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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

Historical rules: <http://www.cbs.state.or.us/wcd/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
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0002 Purpose

The purpose of these rules is to prescribe uniform standards by which insurers shall process workers' compensation claims under ORS 656.726(4). The director has charged the Workers' Compensation Division with the administration and enforcement of the applicable statutes, these rules, and all bulletins pertaining to claims processing. Failure to process claims in accordance with these rules will subject insurers to civil penalty under ORS 656.745; to penalties payable to the claimant under ORS 656.262(11); and, to sanctions under ORS 656.447.

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
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0003 Purpose and Applicability of these Rules

(1) Purpose.

The purpose of these rules is to prescribe uniform standards by which insurers process workers' compensation claims under ORS chapter 656.

(2) Applicability. 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;

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- ~~(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 [rules are subject to the](#) applicability of these rules is subject to [provisions under](#) ORS 656.202.

(33) [Director's discretion.](#)

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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0005 Definitions

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

- (1) "Aggravation" means an actual worsening of the compensable condition(s) after the last award or arrangement of compensation, ~~which is established by medical evidence supported by objective findings, and otherwise~~ [that](#) 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 ~~p~~Paying ~~A~~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 [to release rights or obligations](#) as provided in 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 ORS 656.023.

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~~(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.~~ (7) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

~~(10) "Inpatient" means an injured worker who is admitted to a hospital prior to 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 that 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.~~ (10) "Mailed or mailing date," unless otherwise specified, means:

- (a) The date a document is postmarked;
- (b) The date automatically produced by electronic transmission (e.g. email or facsimile);
- (c) The date a hand-delivered document is stamped or punched in by the recipient; or
- (d) The date of a phone, or in-person requests, when allowed under these rules.

~~(13) "Physical rehabilitation program" means any services provided to an injured worker to prevent the injury from causing continuing disability.~~

(12) "Regularly employed worker" means any worker who receives a regular wage as defined in section (15) of this rule. For workers who are paid a daily wage, "regularly employed" means actual employment or availability for such employment.

(13) "Service company" is the contracted agent for an insurer authorized to process claims and make payment of compensation on behalf of the insurer.

(14) "Suspension of compensation" means:

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

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

(15) "Wage" is as defined in ORS 656.005(29). As used in this rule:

(a) "Irregular wage" means a money rate which is paid at variable rate, or is paid on unscheduled or unpredictable intervals, including but not limited to workers who are seasonally employed, on call, paid hourly, or are paid by piece rate.

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(b) "Regular wage" means a money rate which is paid at a constant rate at uniform intervals including, but not limited to, wages paid on a daily or weekly basis. Notwithstanding subsection (a), hourly wages may be considered regular if the same number of hours are worked each pay period.

(16) "Wage earning agreement" means the verbal or written contract of hiring or terms of employment made between the worker and employer.

~~(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 means 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 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0006 Administration of Rules

~~Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and these rules are considered orders of the director.~~

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
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0008 Administrative Review and Contested Cases

(1) Request for hearing on a matter concerning a claim.

~~Any party as defined by ORS 656.005, including or 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 and the Workers' Compensation Board's Rules of Practice and Procedure for Contested Cases.~~

~~except where otherwise provided in ORS chapter 656.~~

(2) Contested case hRequest for hearings on proposed f sSanctions and -or cCivil pPenalties.:

~~Any party as described in section (1), or assigned claims agent, aggrieved by a proposed order or proposed assessment of civil penalty of the director issued under ORS 656.254, 656.260, 656.735, 656.740, 656.745 or 656.750 may request a hearing by the Hearings Division. To request a hearing, the party must:~~

(a) Mail or deliver a written request for hearing to the Worker's Compensation Division within 60 days of the mailing date of the proposed order or assessment; and the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

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(b)

~~(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, in the request, the grounds upon which the person requesting the hearing party 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) Administrative review of a matter other than a matter concerning a claim.**

Any party, or assigned claims agent, aggrieved by an action taken under these rules may request the director to conduct an administrative review of the action.

(a) To request administrative review, the party must:

(A) Mail or deliver a written request for review to the Worker's Compensation Division within 90 days of the contested action; and

(B) Specify, in the request, the grounds on which the party contests the proposed order or assessment.

(b) Requests mailed more than 90 days after the contested action may be considered if the director determines there was good cause for delay, or that substantial injustice may otherwise result.

(4) Request for hearing on an other action or order of the director. ~~Hearings before an administrative law judge:~~

~~Under ORS 656.704(2), a~~ Any party, or an assigned claims agent, that disagrees with an action or order of the director under these rules, other than as described in section (1) and (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.~~

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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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0009 Access to Department of Consumer and Business Services Workers' Compensation Claim File Records

(1) Purpose.

Under ORS 192.430 and OAR 440-005-0015(1) the director, as custodian of public records, ~~promulgates~~ adopts this rule to protect the integrity of claim file records and prevent interference with the regular discharge of the department's duties.

(2) Access to Public Records.

The department rules on Access of Public Records, Fees for Record Search and Copies of Public Records are found in OAR 440-005, accessible at: http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_440/440_005.html.

~~Payment of fees for access to records must be made in advance unless the director determines otherwise.~~ (a) The director will provide the first copy of any document without charge to a Workers-worker, worker's attorney, and insurers of record, or their legal representatives and third-party administrators service companies shall receive a first copy of any document free without charge.

(b) Additional copies shall will be provided at the rates set forth in OAR 440-005. Payment of fees for access to records must be made in advance unless the director determines otherwise.

(3) Inspection of nonexempt public records.

Any person has a right to inspect and obtain copies of 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) Inspection of exempt records.

~~Under ORS 192.502(20) w~~ 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~~ service companies administrators 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).~~

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(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 worker's claim record.

(5) Release of records to other persons.

The director may release workers' compensation claims records to persons other than those described in section (4) of this rule when the director determines such release is in the public interest and -

~~(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, -including 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.~~

(a) The determination whether the request to release workers' compensation claims records meets those conditions ~~shall is~~ 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, and to ensure the confidentiality of the disclosed records. 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) Revocation of access to exempt records.

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~~ that violates these rules or any law of the State of Oregon or the United States.

(7) Requests for records.

A Request request to inspect or obtain copies of workers' compensation claim records ~~must~~ may be made in writing, ~~or~~ in person, or by phone.

(a) and Written requests must include:

(aA) The name, address and telephone number, and email address of the requester;

(bB) The reason for requesting the records;

(cC) A specific identification sufficiently detailed description of the public-record(s) ~~required~~ requested;

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and the format in which they are required;

(~~d~~D) The format and number of copies ~~required~~requested; and

(~~e~~E) The account number of the requester, when applicable.

(b) In addition to the information required in subsection (a), request made by telephone or facsimile transmission must include:

(A) The worker's Social Security number; and

(B) The Insurer claim number.

(c)

~~(8)~~ Except as prescribed in subsections (4)(a) through (d) of this rule, a request to inspect or obtain copies of a worker's compensation claims records must be accompanied by person must submit to the division an attorney retainer agreement or release signed by the claimant worker in order to inspect or obtain copies of workers' compensation claims records.

(A) 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.

(B) Upon request, the director will review proposed release forms to determine whether the proposed release is consistent with the law and this rule.

(8) Retention of records.

The director will retain or destroy records according to retention schedules published by the Secretary of State, Archives Division.

Statutory authority: ORS 192.502, 656.704 and 656.726(4)

Statutes implemented: ORS 656.704 and 656.726(4)

Hist: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0010 Reporting Requirements

(1) Employer and worker responsibilities.

A subject employer must accept notice of a claim for workers' compensation benefits from an injured worker or the worker's ~~representative~~attorney.

(a) The employer must provide a copy of the Form 801, "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.~~

~~(2b)~~ A Form 827, "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 ~~may shall~~ start the claim process, but ~~shall~~ does not relieve the worker or employer of the responsibility of filing a Form 801.

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~~(c) If a worker reports~~ provides notice of an accident or injury claim using an electronic ~~formally~~ 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.

(32) Timeframe for notice.

~~Within five days of the~~ 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 any supervisor or manager of the employer (any supervisor or manager) first knew knows of a claim written request for compensation, or of when the employer has enough facts to reasonably conclude that workers' compensation liability is a possibility.;

(a) An employer, except a self-insured employer, must report the claim to its insurers; and

(b) The report must provide the information requested on the Form 801, and include, but not be limited to, at least:

(A) the The worker's name, address, and Social Security number,

(B) the The employer's legal name and address; and

(C) the The data information specified by required under ORS 656.262 and 656.265.

(43) Injuries not requiring medical services.

The employer is not required to notify the insurer of an ~~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~~ accident that an injured worker does not require the worker to seek only first aid treatment from a licensed medical service provider, subject to the following:

(a) The employer must report the claim to the insurer under section (2) of this rule, if:

(A), no notice need be given the insurer, unless the The worker chooses to file a claim;

(B), If a The worker signs a a Form 801; and

(C) T he claim must be reported to the insurer. If the person must be licensed to legally provide the treatment or if a he worker or employer is billed for the service will result treatment; or, notice must be given to the insurer.

(D) The employer learns that the injury has resulted in medical services, disability or death. For the purposes of this paragraph, the date of that knowledge under section (2) of this rule is the date the employer received notice or knowledge of the medical services, disability, or death; and

(b) When If the employer does not give the insurer notice under this section ~~the worker requires only first aid and chooses not to file a claim;~~

(A) the The employer must maintain records showing the name of the worker, the date, nature of the injury and first aid treatment provided, for five years; and;

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(B) These records shall ~~must~~ be open to ~~available for~~ inspection by the director, ~~or any party or its representative~~ the worker or the worker's attorney, if any, and the insurer.

~~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.~~

(54) Civil penalty for failure to report claims:

The director may assess a civil penalty under OAR 436-060-0200 against an employer that:

(a) Is late delinquent in reporting to its insurer more than claims to its insurer in excess of ten percent of ~~the~~ its employer's total claims during any quarter; or

(b) (6) An employer intentionally or repeatedly paying compensation in lieu ~~of~~ stead 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.~~

(57) Insurer responsibilities.

The insurer must process and file claims and reports required by the director in compliance with ORS chapter 656, OAR chapter 436, and orders of the director. ~~WCD administrative rules, and WCD bulletins.~~

(a) All forms must be legible and include all information required by this rule.

(b) Such filings shall not be made by ~~The insurer may not submit~~ computer printed forms, or their electronic equivalents, by email, facsimile transmission (FAX), electronic data interchange (EDI), or other electronic means, ~~unless~~ without the specifically director's prior authorization ~~by the director.~~

(c) Electronic forms, when allowed, must include the same fields and elements of their paper counterparts.

(68) Misdirected claims.

~~When~~ If an insurer receives a claim and ~~the insurer d~~ idoes not provide insurance coverage for the worker's employer on the date of injury, the insurer may must check for other coverage ~~or forward it~~ the claim to either the correct insurer or the director. The insurer must do one or the other within three days of the date it ~~determining~~ determined ~~they it did was~~ not provide coverage responsible for the claim ~~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.~~

(79) Identification of insurer.

The insurer or self-insured employer and third party administrator, if any, must be identified ~~on a~~ All insurer generated workers' compensation forms generated by the insurer must, include:

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(a) ~~The~~ insurer's name;

(b) ~~The~~ third party administrator service company's name, (if applicable); and

(c) ~~the~~ The mailing address and phone number of the location responsible for processing the claim.

(108) Claims status and activity reporting.

The insurer must ~~file~~ report all disabling claims status and activity ~~with~~ to the director using Form 1502, "Insurer's Report."

(a) The insurer must file a Form 1502 with the director within 14 days of:

(A) The date of ~~the~~ the insurer's initial decision either to accept or deny the claim.

(B) The date of any reopening of the claim, except voluntary reopening under ORS 656.278;

(C) The date of a change in the acceptance or classification of the claim following the initial Form 1502;

(D) The date of a litigation order or insurer's decision that changes the acceptance or classification of the claim, or causes the claim to be reopened;

(E) The date a worker is enrolled in a managed care organization that occurs after the initial Form 1502 has been filed;

(F) The date the insurer has knowledge that a previously filed Form 1502 contained erroneous information;

(G) The date of a denial that occurs after the initial Form 1502 has been filed; or

(H) The date first payment of temporary disability is issued, if the date was not included in the initial Form 1502.

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.

(b) Each Form 1502 ~~(11) When submitting a Form 1502~~ the insurer files must include at least the following information: the minimum data elements an insurer must provide are

(A) ~~the~~ The worker's legal name;

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(B) The worker's Social Security number; Number;

(C) The insurer's claim number;

(D) The date of injury;

(E) and the employer's legal name;

(F) The employer's policy number;

(G) The status of the claim; and

(H) The reason for filing.

(c) The

~~(12) When submitting an initial compensability decision Form 1502, reporting the insurer's initial decision to accept or deny a claim must also include the insurer must report:~~

~~(a) The status of the claim;~~

~~(b) Reason for filing;~~

~~(eA) Whether~~ If the first payment of compensation was timely made within the timeframe required under OAR 436-060-0150, if applicable;

~~(dB) Whether~~ If the claim was accepted or denied timely within the timeframe required under OAR 436-060-0140; and

~~(eC) If the worker is Any enrolled in a Managed Care Organization (MCO) enrollment, and the date of enrollment, if applicable.~~

(9) Filing the first Form 1502 on a claim.

The first Form 1502 the insurer files on a claim must be accompanied by:

(a) Copies of all acceptance or denial notices not previously submitted to the director; and

(b) A signed Form 801, or its electronic equivalent, except when a Form 801 is not available for timely filing.

(A) The Form 801 must be completed by the employer and worker, unless:

(i) The Form 801 cannot be obtained from the employer or worker because the employer or worker can not be located, refuses to cooperate, or is physically unable to complete the form; or

(ii) The Form 801 is submitted using an electronic form that requires it to be prepared by the insurer based upon information obtained from the employer and worker.

(B) If a Form 801 is not available for timely filing:

(i) The Form 1502 may be accompanied by a signed Form 827 to satisfy the initial reporting requirement; and

(ii) The Form 801 must be submitted within 30 days of the date the insurer filed

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the first Form 1502.

~~(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.~~

(1410) Nondisabling claims.

The insurer ~~A nondisabling claim is not required to~~ must be report a nondisabling claim to the director, except: ~~only if it is denied~~

(a) The insurer must report , in part or whole. ~~It a nondisabling claim that is denied in part or whole must be reported to the director within 14 days of the date of denial, and.~~

(b) The insurer must report ~~A a nondisabling claim that that is reclassified as~~ becomes disabling ~~must be reported to the director within 14 days of the date of the status change.~~

(1511) Voluntarily reopened own motion claims.

~~If~~ The insurer voluntarily reopens a qualified claim under ORS 656.278, it must file a Form 3501, "Notice of Voluntary Reopening Own Motion Claim," ~~with the director within 14 days of the date the insurer reopens~~ voluntarily reopens a qualified claim under ORS 656.278 ~~the claim.~~

(1612) New condition reopening.

If ~~The insurer~~ reopens a claim due to a ~~must report~~ a new medical condition, and the claim:

(a) Is not closed within 14 days, the insurer must file ~~reopening on the~~ Form 1502 with the director ~~if the claim cannot be closed within 14 days of the earliest date t of the first to occur: acceptance of the new condition is accepted,~~ or ~~the insurer has's knowledge that interim temporary disability compensation is due and payable; or.~~

(b) Is closed within 14 days, the insurer must file Form 1503,

~~(17) New condition claims that are ready to be closed within 14 days must be reported on the "Insurer Notice of Closure Summary;"~~ with the director ~~Form 440-1503 (Form 1503) at the time the insurer closes the claim. The Form 1503 must be accompanied by: T~~ the "Modified Notice of Acceptance" and "Updated Notice of Acceptance at Closure" sent to the worker ~~letter must accompany the Form 1503.~~

(1813) Claim withdrawal.

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~~The insurer must file a Form 1502 with the director -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," after the claim has been reported, the The insurer must submit a Form 1502 must be accompanied by with a copy of the worker's communication, to the director, if the claim had previously been reported.~~

(1914) Failure to report.

The director may issue a civil penalty against any insurer that does not file required notices and forms within the timeframes of these rules. ~~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).~~

(2015) Reporting of legal service costs.

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~~ provided by the director for that purpose. Reports for each calendar year must be filed not later than March 1 of the following year.

(2116) Election of payment of supplemental disability.

~~If an insurer elects to not process and pay supplemental disability benefits under ORS 656.210(5)(a) and OAR 436-060-0035:~~

~~(a) The insurer must submit Form 3530, "Supplemental Disability Election Notification," under ORS 656.210(5)(a) to the director. The insurer does is not need required to inform the director if their it election elects to process and pay supplemental disability unless the insurer has previously provided notice otherwise.~~

~~(b) The insurer must use request reimbursement, under OAR 436-060-0500, by filing Form 3504, "Supplemental Disability Benefits Quarterly Reimbursement Request," to request reimbursement under OAR 436-060-0500 with the director for any each quarter during which they the insurer 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 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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

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See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0012 Notices and Correspondence Following the Death of a Worker

- (1) If a worker is deceased, regardless of the cause of death, an insurer must address all future notices and correspondence to the worker's estate or qualified beneficiaries.
- (2) If a worker is deceased, regardless of the cause of death, an insurer must still provide a written notice of acceptance or denial of a claim and issue a Notice of Closure, when applicable, to the estate of the worker.
- (3) Other notices required under this chapter intended for the worker are not required when the worker is deceased.

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

See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0015 Required Notice ~~And~~ and Information

(1) Notice to worker's attorney.

If a worker is represented by an attorney, and the ~~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~~ that 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) Penalty for failure to provide notice to worker's attorney.

The director ~~shall~~ may assess a civil penalty against an insurer ~~who~~ that intentionally or repeatedly fails to give notice as required under section (1) of this rule.

(3) Information provided to worker.

The insurer or the ~~third party administrator~~ service company must provide:

(a) the pamphlet Form 1138, "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 disability check or earliest written correspondence. For nondisabling claims, the information page Form 3283, "A Guide for Workers Recently Hurt on the Job," Form 440-3283 (Form 3283) may be provided in lieu place of Form 1138, unless the worker specifically requests Form 1138.

(4b) The insurer must provide Form 3283 to their its 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.

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(5c) ~~The insurer must provide the Form 3058, "Notice to Worker," Form 440-3058 (Form 3058) or its an equivalent form to the worker with the initial notice of acceptance on of the claim under OAR 436-060-0140(7). If an equivalent form is provided, it For the purpose of this rule, an equivalent to the Form 3058 must include all of the statutory and rule requirements information included on Form 3058.~~

(6d) ~~The Additional additional notices the insurer must send to a worker are contained in required under 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.~~

(47) Notice of change of processing location.

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, email address, and mailing address of the new claim processor.

(58) Notice of change in rate of compensation and benefit amounts.

When the insurer changes the rate of compensation, the wage used to calculate benefit amounts, or the method of calculation used to determine benefits. ~~The the~~ insurer must provide ~~the worker a~~ written ~~n~~ explanation of any change to the worker and the worker's attorney, if any.

(6) Notice of wage used to calculate benefits at closure. ~~in the wage used that differs from what was initially reported in writing to the insurer. Prior to~~

~~Before closure of a disabling claim claim closure on a disabling claim, the the~~ insurer must send a notice to the worker ~~a notice that:~~

~~(a) documenting~~ Documents the wage upon which benefits were based;

~~(b) Informs the worker that -W~~ work disability, if applicable, will be determined when the claim is closed; and -

~~(c) The notice must also e~~ Explains 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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0017 Release of Claim Documents

(1) Definitions.

For the purpose of this rule:

(a) "Documents" means the written records making up, or relating to, the worker's claim, includ including e, but are not limited to:

(A); mMedical records;

(B); -vVocational records; ;

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~~(C) written and automated p~~Payment ledgers for both ~~time loss~~temporary disability and medical services;

~~(D) p~~Payroll records;

~~(E) r~~Recorded statements;

~~(F) i~~Insurer generated records, ~~(insurer generated records exclude~~excluding a claim examiner's generated file notes, such as documentation or justification concerning setting or adjusting reserves, claims management strategy, or any privileged communications;)

~~(G); -A~~ll forms on the claim ~~required to be filed~~ with the director;

~~(H) n~~Notices of closure; and

~~(I) E~~lectronic transmissions, ~~and~~ ecorrespondence between the insurer, service providers, claimant, the ~~division~~director, or the Workers' Compensation Board.

(b) "Possession" means the documents ~~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~~had been generated or received by the insurer five or more working days ~~prior to~~before the date of mailing, ~~shall be considered as part of the insurer's claim record even though~~ if the documents ~~may~~had not have yet reached the insurer's claim file.

(2) Date of receipt.

The insurer must ~~date-stamp~~ or display evidence of the initial date of receipt on each document ~~upon receipt with the date it is received~~in its possession.

(a) The date-stamp or evidence must include the month, day, year of receipt, and name of the company;

(b) Acceptable evidence under this section includes, but is not limited to, a machine produced date stamp or the data automatically produced by ~~unless the document already contains the date information and name of recipient company, as in faxes, e-mail and other electronically transmitted communications~~ssion.

(3) Requests for claims documents.

~~A request for copies of claim documents must be submitted to the insurer, self-insured employer, or their respective third party administrator, and copied simultaneously to defense counsel, if known.~~

~~(4) The insurer~~ or service company must ~~furnish~~provide, without ~~cost~~charging a fee to the recipient, legible copies of documents in its possession relating to a claim, upon request of the ~~claimant~~worker, ~~claimant's~~worker's attorney or ~~claimant's~~worker's beneficiary, at times other than those provided for under ORS 656.268 and OAR chapter 438, as provided in this rule.

(a) A request for copies of claim documents must be submitted to the insurer or service company, and copied simultaneously to the insurer's defense counsel, if known.

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(b) Except as provided in OAR 436-060-0180, an initial request by anyone other than the claimant ~~worker~~ or claimant's ~~worker's~~ beneficiary must be accompanied by an ~~worker~~ signed-attorney ~~retention-retainer~~ agreement or a medical release that has been signed by the worker.

(A) The signed medical release must be in a ~~the form or format~~ prescribed as the ~~director may provide by~~ Bulletin 281.

(B) Information not otherwise available through this release, but relevant to the claim, may only be obtained in compliance with applicable state or federal laws.

(c) If the worker or beneficiary is represented by an attorney:

(A) The documents must be mailed directly to the worker's or beneficiary's attorney;

(B) The insurer is not required to provide copies to both the worker or beneficiary and the attorney, however, the insurer must inform the worker or beneficiary that the documents were mailed to the attorney if the documents were requested by the worker or beneficiary; and

(C) If the worker or beneficiary changes attorneys, the insurer must provide the new attorney with copies upon request.

(d) ~~Upon the request of the claimant's attorney, a request for documents shall be considered~~ If the worker or beneficiary's attorney makes an ongoing request for ~~future~~ documents:

(A) The insurer must provide all new documents received and generated by the insurer. The request will remain in effect :

(i) ~~f~~For 180 days after the initial mailing date under section (7) of this rule; or

(ii) ~~u~~Until a hearing is requested before the Workers' Compensation Board; and

(B) ~~The insurer must provide such new documents to claimant~~the worker's attorney every 30 days. ~~If , unless the attorney requests for specific documents are requested sooner by the attorney. Such to be sent more frequently, those documents must be provided within the time-frame of specified in section (7) of this rule.~~

(e) The insurer must provide to the worker or the worker's attorney the entire health information record in its possession, except the following, which may be withheld:

(A) Information that was obtained from someone other than a health care 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; or

(D) Information that must be withheld under federal regulation.

(f)

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~~(5) Once~~ If a hearing is ~~has been~~ requested before the Workers' Compensation Board any request for, ~~documents must be~~ the release made of documents is controlled by under OAR chapter 438, any subsequent requests for documents made. This rule applies subsequently if after the hearing request is withdrawn or when the hearing record is closed must continue to be made under OAR chapter 438, 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)~~ Timeframe to provide documents.

The insurer must ~~furnish~~ provide copies of documents requested under this rule within the following time-frames:

~~(a) Copies of~~ The documents from ~~of files that are~~ open and closed files, or microfilmed files not archived must be mailed within 14 days of receipt of a request; ~~and~~

~~(b) copies~~ Copies of documents ~~of~~ from archived files must be mailed within 30 days of receipt of a request;

~~(c)~~ 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; ~~and~~

~~(e)~~ If ~~no documents are in~~ the insurer's does not possession any documents at the time the request is received;

(A) The insurer must mail any documents relating to the claim it receives to the requestor within the 14 days of receipt of the documents; and

(B) The request will be considered ongoing for 90 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~~

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~~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.~~

(106) Complaints of violation.

~~Rule violation complaints~~ Complaints about a violation of the rules regarding release of requested claims documents must be made 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) of this rule.

(a) When notified by the director that a complaint has been filed, the insurer must mail or deliver a written response ~~ed 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~~ director's inquiry letter. A copy of the response, including any attachments, must be ~~sent~~ simultaneously mailed to the requester of claim documents.

(b) 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.

(7) Failure to provide documents.

The director may assess a civil penalty against an insurer that fails to provide documents as required under this rule. The matrix attached to these rules in Appendix "A" will be used in assessing penalties.

Statutory authority: ~~ORS 656.360, 656.362,~~ ORS 656.704, 656.726(4), and 656.745
Statutes implemented: ORS 656.360, 656.362, ~~ORS and 656.704 and 656.726(4)~~
Hist: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0018 Nondisabling/Disabling Reclassification

(1) General.

~~When~~ If 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) The insurer must ~~A notice of change of classification must be communicated~~ send the worker and the worker's attorney, if any, ~~by issuing a "Modified Notice of Acceptance." This~~ The notice must include an explanation of the change in status ~~and must be sent to the~~

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~~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).~~

(b) The insurer must notify the director under OAR 436-060-0010; and

(c) If the claim qualifies for closure, the insurer must close the claim under ORS 656.268(5).

(2) Reclassification of a nondisabling claim.

The insurer must reclassify a nondisabling claim to disabling:

~~(a) within~~ 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)~~ (A) Temporary disability is due and payable; ~~or~~

~~(b)~~ (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)~~ (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; ~~or~~

~~(3b) 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.

(34) Worker request for reclassification.

A worker may request for the insurer to review the classification of a nondisabling claim under ORS 656.277 if a the 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.;

~~(a) the~~ The request worker may request reclassification by submitting a written request for review of the classification status must be made to the insurer in writing, ~~under ORS 656.277.~~

~~(5b)~~ (5b) Within 14 days of receipt of the worker's request, the insurer must review the claim and;

~~(a)~~ (A) If the classification is changed to disabling, provide notice under this rule; or

~~(b)~~ (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:

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Insert current address and telephone number of the Workers' Compensation Division, Appellate Review Unit, here.]."

~~(6c) A~~ If the worker ~~dissatisfied~~ disagrees with the decision in the Notice of Refusal to Reclassify may appeal to the director.

(A) Such ~~The~~ appeal must be made no later than the 60th day after the mailing date of the Notice of Refusal to Reclassify ~~notice is mailed.~~

(B) The appeal must include a copy of the insurer's Notice of Refusal to Reclassify.

(d) Failure of the insurer 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), or both.

(47) Aggravation rights.

A claim for aggravation under ORS 656.273 must be filed within five years of:

(a) The first valid closure of a claim that is ~~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.~~

(8b) The date of injury of a ~~For claims that are~~ is 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).~~

(115) Reclassification of a disabling claim.

~~Notwithstanding (12), once~~ If a claim has been accepted and classified as disabling; ~~for more than one year from date of acceptance~~

(a) ~~All~~ aspects of the claim are classified as disabling and may not be reclassified, unless:

(A) The claim has been classified as disabling for less than one year from date of acceptance;

(B) The insurer determines the criteria for a disabling claim were never satisfied; and

(C) The insurer has notified the worker and the worker's attorney, if any, by issuing a Modified Notice of Acceptance. 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) ~~remain disabling.~~ Any additional conditions or aggravations subsequently accepted must be processed according to provisions governing as disabling claims.;

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(c) Claim closure must be processed 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.~~

(136) Appeal of decision to reclassify a claim.

-If a worker disagrees with the insurer's decision to reclassify the worker's claim, the worker may appeal the decision by requesting review by the director.

(a) The worker's appeal request must be in writing and mailed to the director within 60 days from the date of the notice.

(b) The worker may use Form 2943, "Worker Request for Claim Classification Review," the form specified by the director for requesting review of the insurer's claim classification decision.

(147) Worker's Appeal of reclassification decision.

The worker does not need to be represented by an attorney to appeal the insurer's reclassification decision under section (3) or (6) of this rule. If a worker appeals an insurer's reclassification decision:

(a) The worker's appeal request 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.~~

~~(16b) 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,:~~

(A) †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; and-

(18B) †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.

(19c) After receiving and reviewing the required documents, the director will issue a Director's Review order.

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~~(20A)~~ 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.

~~(21B)~~ 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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0019 Determining and Paying the Three Day Waiting Period

(1) General.

No compensation is due the worker for temporary disability during the first three calendar days after the worker leaves work or loses wages as a result of a compensable injury, unless:

(a) The worker is totally disabled after the injury and the total disability continues for a period of 14 consecutive days; or

(b) 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.

(2) Start of the three day waiting period.

~~Under ORS 656.210 and 656.212, T~~the three day waiting period is three consecutive calendar days beginning with the first day the worker ~~loses time~~leaves work or loses 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, with or without loss of wages, that day shall not is 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.~~

(c) When a work shift extends into another calendar day, the date used to determine the start of the three day waiting period is the date the employer used for payroll purposes.

~~(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~~

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~~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) Initial work day lost.

If compensation is due and payable for the three-day waiting period:-

(a) ~~£~~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;
or-

(b) 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) Workers with irregular or cyclic work schedules.

If a worker is employed with varying days off or cyclic work schedules, the three-day waiting period ~~shall~~ will 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~~ will 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
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0020 Payment of Temporary Total Disability Compensation

(1) Employer payment of benefits.

An employer may pay temporary disability compensation ~~under ORS 656.262(4)~~ with the approval of the insurer ~~under ORS 656.262(13)~~, subject to the following:-

(a) Approving the employer to make ~~Making such payments under this rule~~ does not constitute a waiver or transfer of the insurer's duty to determine the worker's entitlement to benefits or to ensure timely payment of benefits:-

~~or responsibility for the claim to ensure timely benefit payments.~~ (b) An employer approved to make payments under this rule ~~The employer must provide adequate payment documentation as the insurer may require~~ to meet its responsibilities; and

(c) The insurer must reimburse the employer for temporary benefits paid to the worker under this section.

(2) Persons who have withdrawn from the workforce.

~~Under ORS 656.005(30), n~~ 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:

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(a) A person who, ~~prior to~~before 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~~before injury who 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) Authorization from attending physician or authorized nurse practitioner.

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, authorized nurse practitioner, or by a medical service provider under ORS 656.245(2)(b)(B). Temporary disability compensation is authorized when:

(a) The attending physician or authorized nurse practitioner provides the insurer or employer with oral or written verification of the worker's inability to work;

(b) Documents in the insurer's possession at claim closure reasonably reflect the worker's inability to work. For the purposes of this rule "documents" and "possession" have the same meaning as in OAR 436-060-0017(1); or

(c) The director determines there is sufficient contemporaneous medical documentation to reasonably reflect the worker's inability to work upon reconsideration.

(d) A medical service provider who is not the attending physician or authorized nurse practitioner authorizes temporary disability payments under ORS 656.245(2)(b)(B).

(34) Lack of verification of inability to work.

No temporary disability is due and payable for any period of time ~~where~~during which 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.

(a) Before withholding temporary disability under this section, the insurer must ~~inquire of~~ask 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~~does not 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.

(b) 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.

(c) 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

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receiving the verification of any authorized period of ~~time loss~~ temporary disability, 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) Suspension of benefits.

An insurer may suspend temporary disability benefits without authorization from the ~~division~~ director 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 by certified mail 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; and

(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) Requirements for verbal release of work.

If temporary disability benefits end because the insurer or employer s:

~~(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

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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~~ seven 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) Concurrent temporary disability.

When a worker is due concurrent temporary disability under ORS 656.210 or ORS 656.212 ~~is due the worker~~ as a result of two or more accepted claims:

(a) ~~The~~ director 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;

(b) ~~the~~ The insurers may ~~petition~~ request for the ~~division~~ director to make a pro rata distribution of compensation due ~~under ORS 656.210 and 656.212.~~ The request must be in writing, and ~~The~~ the insurer must provide a copy of the request to the worker; and the worker's attorney, if the worker is represented.

(b) ~~The~~ division director's pro rata order ~~shall~~ does not apply to:

(A) ~~any~~ Any periods of interim compensation payable under ORS 656.262; or

(B) Any and also ~~does not apply to~~ benefits due under ORS 656.214 and or 656.245; ~~;~~

(c) 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.~~ (d) The pro rata distribution ordered by the division director shall be only applies effective ~~only for~~ to 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; and.

(e) The insurers may not prorate temporary disability without the approval of the director, except

(8) ~~When~~ when concurrent temporary disability is due ~~the worker~~ as a result of two or more ~~the~~ accepted claims ~~involving~~ involve 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.~~

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(f) The worker must receive compensation at the highest temporary disability rate of the claims involved.

(89) Premature closure.

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.

(109) Incorrectly denied claims.

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 for temporary disability 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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0025 Rate of Temporary Disability Compensation

~~(1) The rate of compensation shall be based on the wage of the worker at the time of injury, except in the case of an occupational disease, for which the rate of compensation will be based on the wage as outlined in ORS 656.210(2)(d)(B).~~ **(1) Continuation of wages, insured employers.**

An eEmployers shall may not continue to pay wages in lieu place of statutory-temporary total disability payments benefits due. However, with the consent of the worker, under ORS 656.018(6) the employer is not precluded from may supplement pay the worker amounts in addition toing the amount of temporary total disability benefits, if the employer paid the worker. Employers must separately identify workers' compensation temporary disability benefits separately from other payments, and shall does not withhold have payroll deductions withheld from such the temporary disability benefits.

(2) Continuation of wages, self-insured employers.

Notwithstanding section (1) of this rule, under ORS 656.262(4)(b), a self-insured employer may continue to pay 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. Such payment will be considered timely payment of temporary disability under ORS 656.210 and 656.212 during the time the wage payments are made. If the self-insured employer continues to pay wages in place of temporary disability benefits:

(a) Normal deductions, including but not limited to, taxes, benefits, and other voluntary deductions, must be withheld; 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.

(b) The claim must The claim shall be classified as disabling.

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(c) The self-insured employer must report to the division the rate and duration of temporary total disability that would have otherwise been paid had wages not continued wages not occurred and the period of disability will be reported to the division.

(d) If the pay interval changes, or the amount of wages decrease, the worker must be paid temporary disability as otherwise prescribed by the workers' compensation law.

(3) Rate of compensation, general.

During the period of temporary total disability the worker must receive compensation equal to 66-2/3 percent of wages, but not more than 133 percent of the State Average Weekly Wage, nor less than the amount of 90 percent of wages a week or the amount of \$50 a week, whichever amount is less.

(a) The benefits of a worker who incurs an injury must be based on the worker's wages at the time of injury.

(b) The benefits of a worker who incurs an occupational disease must be based on the worker's wages at the time there is medical verification that the worker is unable to work because of the disability caused by the occupational disease. If the worker is not working at the time that there is medical verification that the worker is unable to work because of the disability caused by the occupational disease, the benefits must be based on the worker's wages at the worker's last regular employment.

(c) The benefits of a worker who was employed in multiple jobs at the time of injury, and who is eligible for supplemental disability under ORS 656.210(2)(b) and OAR 436-060-0035, must be based on the worker's earnings from all subject employment under OAR 436-060-0035.

(d) When a work shift extends into another calendar day, the date of injury used to determine the wage under this section is the date the employer used for payroll purposes.

~~(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.~~

(45) Rate of compensation, irregular wages.

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~~If~~ The rate of compensation for a workers regularly employed, but paid on other than a daily or weekly basis, or employed with receives irregular wages, or receives earnings that are not based on wages alone, unscheduled, irregular or no earnings the insurer must calculate the worker's rate of compensation under section (3) of this rule based on the weekly average of the worker's total earnings for the period up to 52 weeks preceding the date of injury or verification of disability caused by occupational disease. shall be computed on the wages determined by this rule.

(a) "Total earnings" means all wages, salary, commission and other remuneration for services rendered under the worker's wage earning agreement.

(A) The insurer must include a reasonable value of any in-kind considerations only if the considerations will not continue during the period of disability.

(B) The insurer must not include expenses incurred due to the job and reimbursed by the employer (e.g. meals, lodging, per diem, equipment rental).

~~(a) For workers employed seasonally, on call, paid hourly, paid by piece work or with varying hours, shifts or wages:~~

(bA) If, on the date of injury or verification of disability caused by occupational disease, the worker had been employed by the employer at injury for four weeks or more:

(A) The insurer must divide the workers' total earnings for up to 52 weeks by the number of weeks of employment before the date of injury or verification of disability caused by occupational disease, subject to the following:

(i) The insurer may not include any gap in employment of more than seven consecutive work days that was not anticipated in the wage earning agreement, when calculating weeks of employment.

(ii) If the worker's wage earning agreement changed in the 52 weeks before the date of injury or verification of disability caused by occupational disease, due to reasons other than only a change in rate of pay, including but not limited to, a change of hours worked or a change of job duties, the insurer must average earnings only for the weeks worked under the most recent wage earning agreement.

~~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. (c) 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~~

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employment relationship itself, including whether the parties contemplated that such gaps would occur when they formed the relationship. ~~For~~ If, on the date of injury or verification of disability caused by occupational disease, the worker had been s-employed by the employer at injury for less than four weeks, or the worker's wage earning agreement had been in place less than four weeks, the insurers ~~shall~~ must use base the rate of compensation on the ~~intent~~ terms of the worker's -wage earning agreement in place at the time of injury, 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.~~

(5) Rate of compensation, regular wages.

If a worker receives regular wages, the insurer must calculate the worker's rate of compensation as outlined in ORS 656.210. To determine the worker's weekly wage:

(a) Daily wages must be multiplied by the number of days per week the worker was regularly employed.

(b) Monthly wages must be divided by 4.35.

(c) Wages for other pay intervals must be calculated on an equivalent basis.

(d) Wages paid on a regular cyclic schedule, must be calculated as though the cycle has no scheduled days off.

~~(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.~~

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~~(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).~~

(6i) Volunteer, inmates, etc.

If the Covered workers is with no wage earnings such as a volunteers, jail inmates, or other covered worker that receives no wage earnings, etc., the insurer must must have their benefits computed calculate the rate of compensation based on the same assumed wage as that used to determine 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.~~

(k7) Owners and corporate officers.

~~For~~ If the workers who are is a sole proprietors, partners, officers of a corporations, or limited liability company members including managers, the insurers must use calculate the rate of

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compensation based on the assumed wage ~~on which~~ used to determine 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.~~ (8) Wage Disputes.

If the worker disputes the wage used to calculate the rate of compensation, the insurer must attempt to resolve the dispute by contacting the employer to confirm the correct wage and then contacting the worker with that information. If the worker still does not agree with the wage calculated by the insurer, the worker may request a hearing with the Hearings Division.

~~(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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0030 Payment of Temporary Partial Disability Compensation

(1) Rate of temporary partial disability.

The amount of temporary partial disability compensation due a worker shall ~~shall~~ must be determined by multiplying the workers rate of compensation for temporary total disability by the percentage of wages lost by the worker post injury.

(a) To calculate this amount, the insurer must:

~~(aA) Subtract the worker's~~ single ~~post-injury wage earnings~~ wages by the worker from any kind of work from

~~(b) [The worker's wages at the time of injury used to compute the rate of compensation at the time of injury~~ under OAR 436-060-0025; then

~~(eB) Dividing~~ Divide the difference by the wage earnings used in under subsection (b) by the worker's wages at the time of injury under OAR 436-060-0025 to arrive at the percentage of loss of wages; ~~then~~ and

~~(dC) Multiplying~~ the worker's current rate of temporary total disability compensation for temporary total disability ~~rate~~ by the percentage of loss of wages in subsection (e**b**).

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(b) Post-injury earnings from a secondary employer must only be included in post-injury wages to the extent that the post-injury wages from the secondary employer exceed the wages from the secondary employer at the time of injury.

~~(2c) Notwithstanding section (1), for~~ If the worker's whose rate of temporary total disability compensation is based on an assumed wage, "post-injury wages ~~earnings~~" will must be ~~that~~ calculated by ~~proportion of~~ multiplying the assumed wage ~~which the~~ by the percentage of hours worked before the worker is employed during the period of temporary partial disability. ~~represent as a percentage of the hours worked prior to the injury.~~

(32) Commencement of temporary partial disability.

~~An~~ The insurer shall must stop ~~cease~~ paying temporary total disability compensation and start paying temporary partial disability compensation ~~under section (1) from:~~

(a) The ~~he~~ date an injured worker begins wage earning returns to regular or modified employment, ~~prior to claim closure, unless the worker refuses modified work under ORS 656.268(4)(c)(A) through (F);~~ :

(A) If the worker is with a new employer, ~~and upon request of the insurer~~ asks the worker to provide wage information, it shall be the worker's is responsibility responsible to ~~for provide~~ providing documented evidence of the amount of any wages being earned; and;

(B) ~~If the worker fails~~ Failure to provide documentation, ~~do so shall be cause for,~~ the insurer ~~to~~ may 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~~ (b) 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 date an injured worker fails to begin wage regular or modified earning employment, except when the worker refuses modified work under ORS 656.268(4)(c), and the ~~under the following conditions~~ have been met:

~~(a)~~ (A) The employer or insurer has;

~~(A)~~ (A) Notifieds the attending physician or authorized nurse practitioner;

~~(i)~~ (i) Of the physical tasks to be performed by the injured worker; and

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~~(Bii)~~ ~~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~~ travel to and perform the job;

~~(b)~~ B The attending physician or authorized nurse practitioner has agreeds the employment appears to be ~~within~~ within the worker's capabilities, and the worker is physically able to travel, as a result of the compensable injury, the lesser of:

~~the commute is within the physical capacity of the worker~~ (i) The distance traveled from the worker's residence at the time of injury to the work site; or

(ii) The distance from a worker's residence at the time of the modified work offer to the work site; and

~~(e)~~ C The employer or insurer has confirmed the offer of employment in writing to the worker stating:

~~(A)~~ i The beginning time, date and place;

~~(B)~~ ii The duration of the job, if known;

~~(C)~~ iii The wages;

~~(D)~~ iv An accurate description of the physical requirements of the job; and

~~(E)~~ v 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)~~ D The offer of employment explained 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 the location where the worker customarily reported or worked at the time of injury ~~where the worker was injured,~~ unless the work site is less than 50 miles from the worker's residence, or the job at the time of injury involved multiple or mobile work sites as established by the intent of the employer and worker at the time of hire or as established by the employment pattern prior to before 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

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(v) The offer is not consistent with an existing shift change provision of an applicable union contract; and

(GE) The [offer of employment included 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.”

(6c) ~~The date~~ 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:

(aA) The employer has a written policy of offering modified work to injured workers;

(bB) 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);

(eC) 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

(dD) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker’s capabilities.

(7d) ~~The date~~ 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:

(aA) 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);

(bB) 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

(eC) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker’s capabilities.

(38) [If the modified job no longer exists or offer is withdrawn.](#)

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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) This section applies to a~~ 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.~~

(b) 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 may be considered the same as the worker refusing wage earning employment under ORS 656.325(5)(a).

(c) This section does not apply to those situations described in sections (2)(5b), (6c), and (7d) of this rule.

(49) Termination of temporary partial disability.

When the worker's disability is partial only and temporary in character, temporary partial disability compensation under ORS 656.212 ~~shall~~ must 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~~ director 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.

(510) Post-injury wages.

-In determining failure on the part of the worker in section (5) and for purposes of subsection (1)(a), "post-injury wages" are the sum of:

~~-(a) the~~ The wages the worker could have earned by accepting a job offer, or actual wages earned, whichever is greater; ~~and~~

(b) any Any unemployment benefits received; and; ~~sick or vacation~~

(c) Any wages received for paid leave, payments received except wages paid in addition to temporary disability compensation with the worker's consent under OAR436-060-0025(1).

(611) Verbal work releases.

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

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(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~~seven 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.

(712) Changes in the rate of compensation.

When the insurer stops paying temporary total disability compensation and starts paying temporary partial disability compensation, or otherwise changes the ~~The insurer must provide the injured worker and the worker's attorney a written notice of the reasons for changes in the compensation rate or, and the method of computation~~ of benefits under this rule, the must send written notice to the worker and worker's attorney under OAR 436-060-0015, 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)(e), chapter 865, Oregon Laws 2001~~

Hist: Amended 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06

See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0035 Supplemental Disability for Workers with Multiple Jobs at the Time of Injury

(1) Definitions.

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)~~ (a) "Primary job" means the job at which the injury or occurred, or the job where the worker was employed at the time of verification of occupational injury.

~~(e)~~ (b) "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)~~ (c) "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~~

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~~(B) Adequate information to calculate the average weekly wage in accordance with OAR 436-060-0025.~~

~~(g)~~ “Insurer” has the same meaning as OAR 436-060-0005(9), and also includes third party administrator service companies.

(2) Election to process and pay supplemental disability.

An insurer may elect to be responsible for payment and processing of supplemental disability benefits to a worker employed in more than one job at the time of injury. The director will select an assigned processing administrator who is authorized to process and pay supplemental disability benefits on behalf of the director when the insurer has elected to not process and pay supplemental disability benefits.

(a) If the insurer has elected to process and pay supplemental disability benefits, the insurer must:

(A) Determine the worker’s ongoing entitlement to supplemental disability;

(B) Pay the worker supplemental disability benefits simultaneously with any temporary disability benefits due; and

(C) Maintain a record of supplemental disability benefits paid to the worker, separate from temporary disability benefits paid as a result of the job at injury.

(b) If the insurer has elected not to process and pay supplemental disability benefits:

(A) The assigned processing administrator must determine the worker’s on-going entitlement to supplemental disability and must pay the worker supplemental disability benefits due once each 14 days.

(B) 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.

(c) Reimbursement for supplemental disability paid will be made under OAR 436-060-0500.

(d) The election must be made by the insurer, and applies to all service companies an insurer may use for processing claims.

(e) The election remains in effect for all supplemental disability claims the insurer receives until the insurer changes its election. An insurer may change its election:

(A) Once each year; and

(B) Once, after the director’s first audit of supplemental disability payments made by the insurer.

(3) Eligibility for supplemental disability.

A worker who was employed at one or more secondary jobs with Oregon subject employers a the time of injury or verification of an occupational disease may be eligible to receive supplemental disability if:

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(a) The worker provides notification of the secondary job to the insurer within 30 days of the insurer's receipt of the initial claim; and

(b) The rate of compensation for wages at the primary job under OAR 436-060-0025 is less than the maximum temporary disability rate established under ORS 656.210(1).

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) (4) Insurer request for verifiable documentation.

The insurer must send a written request for verifiable documentation of the worker's wages from any secondary jobs ~~Within~~ within five business days of receiving notice or knowledge that the worker may be eligible for supplemental disability. ~~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) The~~ Send the worker an initial notice must ~~informing the worker~~ what type of information verifiable documentation the worker must submit to the insurer or the assigned processing administrator, ~~must receive to determine the worker's eligibility for supplemental disability.~~

(b) The notice must clearly state that if the insurer or assigned processing administrator does not receive the required

~~(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~~ insurer will determine the worker's temporary disability rate based only on the job at which the injury occurred, and the worker ~~shall~~ will be found ineligible for supplemental disability.

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~~(c) If the insurer has elected not to process and pay supplemental disability benefits under section (2) of this rule the insurer must send also~~ Copy of the notice to the assigned processing administrator, ~~-. In addition to the requirements of this section, if the insurer has elected not to process and pay supplemental disability benefits. T~~ the notice must also:

(A) contain ~~Contain~~ the name, address, email address, and telephone number of the assigned processing administrator; ; and

(B) must ~~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) Worker responsibility to provide verifiable documentation.

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To receive supplemental disability, the worker must provide verifiable documentation of the wages from all secondary jobs at the time of injury or verification of an occupational disease within 60 days of the mailing date of the request for documentation sent under section (4) of this rule. For each secondary job, the documentation must:

- (a) Identify the Oregon subject employer for each secondary job;
- (b) Establish that the worker held the secondary job, in addition to the primary job, at the time of injury or verification of occupational disease; and
- (c) Provide adequate information to calculate the average weekly wage in accordance with OAR 436-060-0025.

(5) Determination of eligibility.

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. If the worker found ineligible for supplemental disability, tThe letter must also advise the worker of -the reason why ~~he/she is~~they are not eligible, and 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) Calculation of supplemental disability.

The insurer or the assigned processing administrator must calculate supplemental disability for an eligible worker by calculating the sum of the rates of compensation for the wages from each secondary job under OAR 436-060-0025. For the purposes of calculating and payment of supplemental disability:

- (a) The total rate of supplemental disability may not exceed the difference between the maximum rate of temporary disability under ORS 656.210(1) and the rate of compensation for wages under the worker's primary job;
- (b) No supplemental disability is due for jobs where the rate of compensation is based on the worker's assumed wage; ~~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).~~
- (c) In no case shall ~~may~~ an eligible worker receive less compensation than would be paid if based solely on wages from the primary employer;:-

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(d) The worker's scheduled days off for the job at which the injury occurred must be used to calculate and pay supplemental disability; and

~~(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) (e) 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.~~

(118) Partial disability.

To establish the combined partial disability benefits wWhen the worker has post-injury wages from either the primary job, or any secondary job:

~~(a) the~~ The insurer or the assigned processing administrator must calculate the rate of temporary partial disability due the worker under OAR 436-060-0030 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 worker's wages from both the primary and secondary jobs.

~~(b) The insurer or the assigned processing administrator must calculate the amount of supplemental disability by subtracting 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 rate of partial disability due from based on wages from only the primary job based only on the primary wages at injury and the primary post injury wages. That amount shall be subtracted from the total amount rate of compensation due the worker; the remainder is the supplemental disability amount.~~

~~(12) (c) If the worker receives post post-injury wages from ~~the~~ the secondary job equal to or greater than the secondary wages at the time of injury, no supplemental disability is due.~~

~~(13) (d) 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.~~

(149) If temporary disability is not due from the primary job.

~~-Supplemental disability may be due on a nondisabling claim even if temporary disability is not due from the primary job.~~

~~(a) The A nondisabling claim will not change to disabling status due to payment of supplemental disability.~~

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(b) 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.~~

(1710) Worker's responsibilities.

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.~~

(2111) Hearings.

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.~~

(a) 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 ~~(56)~~ of this rule. ~~However, t~~

(b) The insurer for the primary job is not required to contact the secondary job employer. The worker is responsible to provide any necessary documentation.

(2212) Sanctions.

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An insurer ~~who~~ that 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. Any delay in the payment of a higher disability rate because of the worker's failure to provide verifiable documentation under section (5) of this rule will not result in a penalty under ORS 656.262(11).

(2313) Third party recovery.

In the event of a third party recovery of supplemental disability benefits:-

(a) previously Previously reimbursed supplemental disability benefits are a portion of the paying agency's lien.

~~(24)~~ (b) Remittance on recovered benefits ~~shall~~ must 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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0040 Payment of Permanent Partial Disability Compensation

(1) General.

Permanent partial disability award 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. Permanent partial disability not exceeding \$6,000 must be paid under OAR 436-060-0060.

(2) Reopened claims.

If a claim is reopened as a result of a new medical condition, or an aggravation of the accepted conditions, resulting from the worker's compensable injury; ~~the worker's accepted condition(s) and temporary disability is due~~

(a) ~~any~~ Any permanent partial disability benefits due must continue; and

(b) If any temporary disability benefits are due, permanent partial disability benefits must ~~to~~ be paid concurrently, ~~with temporary disability benefits.~~

(3) Training programs.

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~~

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~~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 656.216](#), ORS 656.268(10), 656.704, and 656.726(4)
Hist: Amended 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0045 Payment of Compensation During Worker Incarceration

(1) General.

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) Initiation of payments after incarceration.

-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) Right to claim closure.

A worker who is incarcerated ~~shall have~~has 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
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0055 Payment of Medical Services on Nondisabling Claims; Employer/Insurer Responsibility

~~Under ORS 656.262(5) the director will establish the maximum reimbursable amount for medical services. The maximum reimbursable amount will be published annually by Bulletin No. 345. The costs of medical services for nondisabling claims must first be paid by the insurer. Then the insurer may be reimbursed by the employer if the employer so chooses. Such choice does not relieve the employers of their claim reporting requirements or the insurers of their responsibility to determine entitlement to benefits and process the claims accurately and timely. Also, when paid by the employer, such costs cannot in any way be used to affect the employer's experience rating modification or otherwise be charged against the employer. To enable the director to ensure these conditions are met, insurers and employers must comply with the following process and procedures:~~

(1) General.

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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) Notice to employers.

Prior to ~~Before~~ the commencement beginning of each policy year, the insurer must send a notice to the insured or prospective insured employer, advising of the employer's right to reimburse medical service costs up to the maximum amount as published in Bulletin 345 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~~ is the first completed period, established under subsection (3)(a) of this rule, following receipt of the employer's request.

(3) Procedure for reimbursement.

If the employer wishes to ~~make such reimbursement~~ the medical service costs paid by the insurer, and ~~so~~ advises the insurer in writing under section (2) of this rule, the procedure for ~~reimbursement~~ reimbursements is 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. The employer and insurer may, by written agreement, establish a period in excess of 30 days for the employer to reimburse the insurer.

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(c) Failure by the employer to reimburse the insurer within the 30 days allowed by subsection ~~(3)(b) of this rule~~ shall will 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~~ must 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) Records.

The insurers must maintain records of amounts reimbursed by employers for medical services on nondisabling claims. For medical service costs reimbursed under this rule:

(a) The insurers, however, shall may not modify an employer's experience rating or otherwise make charges against the employer based on the costs for any medical services reimbursed by the employer; and:

(b) If the employer is on a retrospective rated plans, the medical costs paid by the employer on nondisabling claims must be included in the retrospective premium calculation, but the insurer must apply the amount paid by the employer shall be applied as credits against the resulting retrospective premium.

(5) Reclassified claims.

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~~ before the change, the insurer ~~shall~~ must 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, the premium must be calculated as provided in section (4) of this rule.

(6) Penalties.

Insurers ~~who~~ that 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~~ may be subject to a penalty as provided by OAR 436-060-0200(7).

(7) Self-insured employers.

Self-insured employers must maintain records of all amounts paid for medical services on nondisabling claims ~~in accordance with~~ under 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- published in Bulletin 345.

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)

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Hist: Amended 11/1/07 as WCD Admin. Order 07-064, eff. 1/1/08
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0060 Lump Sum Payment of Permanent Partial Disability Awards

(1) General.

~~Under ORS 656.230, in all cases w~~When an award for permanent partial disability ~~does not exceed~~is less than \$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~~may request a lump sum payment of all or part of the award. The insurer may only 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~~under ORS 656.340 and 656.726. For dates of injury ~~prior to~~before 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 vocational training program.

(2) Application for Approval.

When an insurer receives a request for a lump sum ~~application-~~payment from the worker or the worker's representative, the insurer must send ~~the lump sum application, Form 1174,~~ "Application for Approval of Lump-sum Payment of Award," to the requestor within ten business days.

(3) Reopening of claims.

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) Approved requests.

If the insurer ~~agrees-~~approves with the worker's request for lump sum payment of a permanent partial disability award in excess of \$6,000, ~~they~~the insurer must make the lump sum payment within 14 days of receipt of the signed application.

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(5) Denied requests.

If the insurer ~~disagrees with~~ denies 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) Claims disposition agreements.

A lump sum payment ordered in a litigation order or ~~which~~ that is a part of a claim disposition agreement under ORS 656.236 does not require further approval by the insurer.

(7) Partial payments.

When a ~~partial~~ lump sum payment for only part of an award is approved by the insurer, it ~~shall~~ must be paid in addition to the regularly scheduled monthly payment. The remaining balance ~~shall~~ must be paid under ORS 656.216. Denial or partial approval of a request does not ~~prevent~~ preclude 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 12/15/08 as WCD Admin. Order 08-065, eff. 1/1/09
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0095 Medical Examinations; Suspension of Compensation; and Independent Medical Examination Notice

(1) General.

A worker must submit to independent medical examinations reasonably requested by the insurer or the director.

(a) The conditions of the examination must be consistent with conditions described in OAR 436-010-0265.

(b) If ~~The division will suspend compensation by order~~ 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), the director may suspend compensation by order:

~~-(A) under conditions set forth in this rule.~~ The worker must have the opportunity to dispute the suspension of compensation ~~prior to~~ before the director will issue ~~ancee~~ of the order.

(B) Compensation will be suspended until the examination has been completed. 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.

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~~(c)~~ Any action of a worker's observer ~~friend or family member which~~ that obstructs the examination ~~shall~~ may be considered an obstruction of the examination by the worker for the purpose of this rule.

~~(d)~~ The ~~division~~ director 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.

(32) Number of examinations.

~~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).~~

(43) Scheduling and Notice to worker.

~~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)~~ When an examination is scheduled by the insurer, or by another party at the request of the insurer,;

~~(a)~~ The worker and the worker's attorney, if any, ~~shall~~ must be simultaneously notified in writing of the scheduled medical examination ~~under ORS 656.331;~~

~~(b)~~ The notice ~~shall~~ must be sent mailed at least 10 days ~~prior to~~ before the examination,;

~~(c)~~ If the third party notifies the worker of a scheduled examination on behalf of the insurer, the appointment notice must be sent on the insurer's stationery; and

~~(d)~~ The notice sent for each appointment, including those which have been rescheduled, must contain the following:

~~(a)~~ A The name of the examiner or facility;

~~(b)~~ B A statement of the specific purpose for the examination and, identification of the medical specialties of the examiners;

~~(c)~~ C The date, time and place of the examination;

~~(d)~~ 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;

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(eE) If applicable, confirmation that the director has approved the examination;

(fF) A statement ~~That 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;

(gG) A statement ~~That 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;

(hH) A statement that ~~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

(iI) 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.”

(e6) The insurer must include with each appointment notice it sends to the worker:

(aA) Form 3921, “Reimbursement for Worker’s Travel, Food, and Lodging,” or ~~A~~ a similar form for requesting reimbursement; and

(bB) ~~The director’s brochure~~ Form 3923, Form 440-3923, “Important Information about Independent Medical Exams.”

(74) Reimbursement of costs.

The insurer must reimburse the worker for a reasonable cost of public transportation or use of a private vehicle and, when necessary, a reasonable cost of child care, meals, lodging and other related services.

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(a) To be reimbursed, the worker must submit a request for reimbursement accompanied by a sales slip, receipt or other evidence necessary to support the request.

(b) If an advance of these costs is necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance;

(c) Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, are considered to be reasonable ~~comply with~~ under this rule.

(86) Requests to authorize suspension.

The director will consider requests to authorize suspension of benefits on accepted claims, deferred claims and denied claims in which the worker has appealed the insurer's denial. 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 in the same manner as for a summons. The request must include the following information:

(a) That the insurer requests suspension of ~~benefits~~ compensation 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 (35) and a copy of any written verification received under subsection (68)(g);

(i) Any other information ~~which~~ that 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

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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.”

(97) Effective date of suspension.

If the ~~division~~ director consents to authorize the suspension of compensation, the suspension ~~shall~~ will be effective from the date the worker fails to attend an examination or such other date the ~~division~~ director 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.

(108) Reinstatement of benefits.

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.

(119) Claim closure.

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(78).

(1210) Denial of suspension.

If the ~~division~~ director denies the insurer's request for suspension of compensation, the insurer will be ~~it shall promptly notified by 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.

(1311) Other actions by the director.

The ~~division~~ director 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~~ is filed a request for hearing
- (b) Order payment of compensation previously suspended ~~where~~ when the ~~division~~ director finds the suspension to have been made in error.
- (c) Reevaluate the necessity of continuing a suspension.

(1412) Final Orders.

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 3/1/11 as Admin. Order 11-052, eff. 4/1/11

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See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0105 Suspension of Compensation for Insanitary or Injurious Practices, Refusal of Treatment or Failure to Participate in Rehabilitation; Reduction of Benefits

(1) General.

The ~~division~~ director will ~~may~~ suspend compensation by order when the worker commits insanitary or injurious acts that 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.

(a) ~~under conditions set forth in this rule.~~ The worker must have the opportunity to dispute the suspension of compensation ~~prior to~~ before issuance of the director will issue an order.

(b) 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) Notice to worker.

The insurer must demand in writing the worker either immediately cease all 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~~ must 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) Failure or refusal to accept medical treatment.

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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) Request for suspension of benefits.

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.

(5a) -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.

(b) 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~~-notice required in section (2);

(f) Any other relevant information including, but not limited to; chart notes, surgical or physical therapy recommendations/prescriptions, and all reccomendations from the attending physician or authorized nurse practitioner-~~reccomendations~~; 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.”

(6c) Any delay in obtaining confirmation or in requesting ~~consent for~~ the 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.

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~~((d7))~~ -If the division ~~director~~ concurs with the request approves authorization of suspension of compensation:

~~(A)~~, it shall issue a An order will be issued suspending compensation from a date established under section (52)(c) of this rule until the worker complies with the insurer's request for cooperation. Where the worker is suspended for a pattern of noncooperation, the ~~division~~ director may require the worker to demonstrate cooperation before restoring compensation.

~~(B)~~ (8) The insurer must make all reasonable efforts to assist the worker to restore benefits when the worker demonstrates the willingness to make such efforts.

~~(C)~~ The insurer must monitor the claim to determine if and when the worker complies with the insurer's requests.

~~(i)~~ 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.~~

~~(10i)~~ -If the worker makes no effort to reinstate benefits within 60 days of the mailing date of the ~~consent~~ suspension order, the insurer must close the claim under OAR 436-030-0034.

~~(D)~~ The director may modify or set aside the suspension order before or after filing of a request for hearing.

~~(E)~~ The director may order payment of compensation previously suspended where the director finds the suspension to have been made in error.

~~(F)~~ The director may reevaluate the necessity of continuing a suspension.

~~(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.~~

~~(G13)~~ An ~~The~~ order will 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.~~

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(e) If the director denies the insurer's request for suspension of compensation, the insurer will be notified 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.

(114) Requests to reduce benefits.

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.

(a) When an insurer submits a request to reduce benefits under this section, the insurer must:

(aA) Specify the basis for the request;

(aB) Include all supporting documentation;

(aC) Send a copy of the request, including the supporting documentation, to the worker and the worker's representative, if any, by certified mail; and

(aD) 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.”

(b15) -The ~~division~~ director shall will 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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0135 Injured Worker, Worker Representative Responsible to Assist in Investigation; Suspension of Compensation and Notice to Worker

(1) Worker's responsibility to assist in investigation.

A worker must submit to and fully cooperate with in person or telephone interviews and other formal or informal information gathering techniques reasonably requested by the insurer. Interviews may be recorded on audio or video by one or more of the parties if prior written notice is given of the intent to record an interview.

(2) Request to suspend compensation.

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~~The insurer may request for the director to suspend compensation by order w~~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), under the following conditions:-

~~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.~~

~~(2a) 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, t~~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. (A) The notice must be sent to the worker and copied to the worker's attorney, if any represented, an~~and must contain the following:

~~(i) advise the worker of t~~The date, time and place of the interview:

~~(ii) and/or a~~Any other reasonable investigation requirements:-

~~(iii) 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 t~~That the interview, deposition, or any other investigation requirements are related to the worker's compensation claim; and:-

~~(iv) The notice must also contain t~~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 do not reasonably cooperate with the investigation of this claim, payment of your compensation benefits

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may be suspended and your claim may be denied in accordance with ORS 656.262 and OAR 436-060.”

(B) If the insurer contracts with a third party to investigate the claim, the notice must be on the insurer's stationery and must meet the requirements of section (3).

(C) The worker must be given 14 days to cooperate with the notice.

(5b) The director will consider requests to authorize suspension of benefits only after the worker has been given at least 14 days to cooperate with the notice under subsection (a) of this rule; and under the following conditions:

(A) The director will only consider requests in claims on which no acceptance or denial has been issued;

(B) The worker must have the opportunity to submit information disputing the insurer's request for suspension of compensation before the director will issue an order;

(C) The director may determine whether special circumstances exist that would not warrant suspension of compensation for failure to cooperate with an investigation;

(D) The insurer must make the request to suspend benefits to the director in writing, and must send 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.

(E) The insurer's 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 (43) 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.

(6c) After receiving the insurer's request to suspend benefits, as required in section (5) of this rule, the division director will promptly notify all parties that:

(A) The worker's benefits will be suspended in five working days unless:

(i) 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

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(ii) ~~unless~~ The insurer notifies the division that the worker is now cooperating.

~~(B) 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.

~~(d) (7)~~ If the worker cooperates after the insurer has requested suspension within five days of the director's notice under subsection (c), the insurer must notify the division director immediately to withdraw the suspension request, upon receiving the insurer's notification: -

~~(A) The division director will notify all the parties~~ of the withdrawal.

~~(B) The director may issue a~~ An order may be issued identifying the dates during which the insurer's obligation to accept or deny the claim was suspended.

~~(8e)~~ If the worker documents the failure to cooperate was reasonable within five days of the director's notice under subsection (c), ~~the division director~~ 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; and.

~~(9f)~~ If the worker has not cooperated with the investigation, or documented that the failure to cooperate was reasonable within five days of the director's notice under subsection (c), the division director will issue an order suspending all or part of the payment of compensation to the worker: ;

~~(A) The suspension~~ of compensation will be effective from the fifth working day after the date of the director's notice is provided by the division as required by under subsection (c)(6) of this rule, and ~~The suspension of compensation shall~~ will remain in effect until the worker cooperates with the investigation.

~~(B) If the~~ The worker begins cooperating with the investigation, the ~~and~~ insurer must notify the division reinstate the worker's benefits immediately ~~immediately; or~~ when the worker cooperates with the investigation.

~~(C) If the worker makes no effort to~~ reinstate compensation cooperate 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).

(103) Request for penalty against worker's attorney.

~~Under ORS 656.262 (14), a~~ An insurer who ~~that~~ believes ~~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~~ director will consider assessment of a civil penalty against the attorney of not more than \$1,000.

~~(a) The worker's attorney must have the opportunity to dispute the allegation~~ prior to before the issuance of a penalty is assessed.

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~~Notice under this section must be sent to the division.~~ (b) 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 this rule.

Failure to comply with the requirements of this rule will be grounds for denial of the insurer's request. Any delay in requesting suspension under section (2) of this rule may result in authorization being denied.

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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0137 Vocational Evaluations for Permanent Total Disability Benefits; and Suspension of Compensation

(1) Requests for vocational evaluations.

A worker receiving permanent total disability benefits must attend a vocational evaluation reasonably requested by the insurer or the director.

(2) Allowed number of vocational evaluations.

The insurer may request no more than three separate vocational evaluations without authorization from the director., ~~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 obtain authorization from the director for additional vocational evaluations may be assessed a civil penalty.~~

~~(a) The process for To requesting authorization the insurer must: is as follows:~~

~~(a) The insurer must sSubmit a written request for authorization to the director in a form and format as prescribed by the director that, which includes but is not limited to:~~

- ~~(i) the The reasons for an additional vocational evaluation;~~
- ~~(ii) The conditions to be evaluated; dates, times, places, and purposes of previous evaluations;~~
- ~~(iii) Copies of previous vocational evaluation notification letters to the worker; and~~
- ~~(iv) any Any other information requested by the director.;~~ and

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- (~~b~~**B**) ~~The insurer must provide a copy of the request to the worker and the worker's attorney.~~
- (~~3~~**b**) The director will review the request and determine if additional information is needed.
- ~~(A)~~ Upon receipt of a request for additional information from the director, the parties will have 14 days to respond.
- (B)** If the parties do not provide the requested information, the director will approve or disapprove the request for authorization based on available information.
- (~~4~~**c**) 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~~**d**) ~~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) Notice to worker.

The insurer must notify the worker of the evaluation notice must be sent to the worker at least 10 days ~~prior to~~ before the date of evaluation.

(a) The notice sent for each evaluation, including those which evaluations that have been rescheduled, must contain the following:

- ~~(a)~~**A**) The name of the vocational assistance provider or facility;
- ~~(b)~~**B**) A statement of the specific purpose for the evaluation;
- ~~(c)~~**C**) The date, time and place of the evaluation;
- ~~(d)~~**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)~~**E**) If applicable, confirmation that the director has approved the evaluation;
- ~~(f)~~**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)~~**G**) The following notice in prominent or bold face type:

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“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 do not attend or fail to do not 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.”

(b) 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 meet the requirements of this section.

(84) Reimbursements of costs.

The insurer must pay the costs of the vocational evaluation and related services ~~reasonably~~ necessary to allow the worker to attend the evaluation, including a reasonable cost of public transportation or use of a private vehicle, and when necessary, a reasonable cost of child care, meals, lodging and other related services. Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, comply with this rule.

(95) Suspension of compensation.

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~~ director may suspend the worker’s compensation by order, under the following conditions:-

~~(10)~~ (a) 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.

(b) The request must include the following information:

(aA) That the insurer requests suspension of benefits under ORS 656.206 and OAR 436-060-0137;

(bB) What specific actions of the worker prompted the request;

(cC) 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;

(dD) 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;

(eE) 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;

(fF) 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

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from the worker or the worker's representative will be sufficient documentation with which to request suspension;

(~~g~~**G**) A copy of the letter required in section (~~7~~**3**) and a copy of any written verification received under ~~subsection~~ paragraph (~~10~~**F**)(~~f~~);

(~~h~~**H**) Any other information ~~which~~ that supports the request; and

(~~i~~**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~~**c**) ~~If the division~~ director suspends compensation:

(~~A~~) ~~the~~ The suspension will be effective from the date the worker fails to attend a vocational evaluation or such other date the ~~division~~ director ~~deems~~ determines is appropriate until the date the worker attends the evaluation; ~~:-~~

(~~B~~) 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~~**C**) 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~~**D**) ~~The division~~ director may also:

(~~a~~) Mmodify or set aside the suspension order before or after filing of a request for hearing;

(~~b~~) E The director may ~~Order~~ order payment of compensation previously suspended where the ~~division~~ director finds the suspension to have been made in error; ~~or~~ and

(~~e~~) F The director may Rreevaluate the necessity of continuing a suspension.

(d) If the insurer fails to comply with this rule, the director may deny the request for suspension. Any delay in requesting suspension may result in suspension being denied or the date of suspension being modified.

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~~(15e)~~ -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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0140 Acceptance or Denial of a Claim

(1) Claim investigations.

The insurer is required to conduct a "reasonable" investigation based on all available information in ~~ascertaining~~ determining whether to deny a claim.

(a) 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.

(2b) 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.

(32) Notice to worker.

The insurer must give the ~~claimant~~ worker written notice of acceptance or denial of a claim within the following timeframes:

(a) For claims with a date of injury before January 1, 2002, within -90 days ~~after of~~:

(A) the ~~The~~ employer's notice or knowledge of an initial claim;

(B) or the ~~The~~ insurer's receipt of a ~~form~~ Form 827 signed by the worker or the worker's representative, and the worker's attending physician indicating an aggravation claim; or

(C) written ~~Written~~ notice of a new medical condition claim, ~~for claims with a date of injury prior to January 1, 2002; or~~

(b) For claims with a date of injury on or after January 1, 2002, within 60 days ~~after of~~:

(A) the ~~The~~ employer's notice or knowledge of an initial claim;

(B) or the ~~The~~ insurer's receipt of a ~~form~~ Form 827 signed by the worker or the worker's representative and the worker's attending physician indicating an aggravation claim; or

(C) written ~~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) For claims with any date of injury, if 90 days ~~after the employer's notice or knowledge of the claim if the worker challenges the location of an independent medical~~

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examination under OAR 436-010-0265 and the challenge is upheld, ~~regardless of the date of injury~~ within 90 days after the employer's notice or knowledge of the claim.

(43) Penalty for untimely acceptance and denials.

The director may assess a penalty under OAR 436-060-0200 against any insurer delinquent in accepting or denying a claim beyond the ~~days~~ timeframe required ~~in~~ under section (32) of this rule in excess of 10 percent of their total volume of reported disabling claims during any quarter.

(54) Notice of Acceptance.

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~~(4)~~ 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.

(56) Notice of Acceptance, fatal claims.

In the case of a ~~On~~-fatal claims, the notice must be addressed "to the estate of" the worker and the requirements ~~in~~ of (5)(a) through (h) ~~shall~~ must not be included.

(76) Initial, Updated, and Modified Notices of Acceptance.

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(a) 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.

(b) 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.~~ To correct an omission or error in an "Updated Notice of Acceptance at Closure", under OAR 436-030-0015(1)(c)(D), the insurer must add the word "Corrected" to the notice.

(c) ~~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~~ the insurer:

(a) Accepts a new or omitted condition: on a nondisabling claim, while a disabling claim is open or after claim closure;

(b) Accepts an aggravation claim;

(c) Changes the disabling status of the claim; or

(d) Amends a notice of acceptance, including correcting a clerical error, except for an error on an Updated Notice of Acceptance at closure.

~~(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.~~

(79) Acceptance of new or omitted conditions.

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. When a claim is reopened, the notice of acceptance must specify the condition(s) for which the claim is being reopened.

(108) Notice of denial.

~~-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 ~~W~~worker ~~R~~requested ~~M~~medical ~~E~~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~~

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(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; and;

(d) If paragraph (408)(a)(B) or (C) above applies, the denial notice must also include the division's ~~W~~web-site address and toll free phone ~~Info~~line-number for the worker's use in obtaining a brochure about the ~~W~~worker ~~R~~requested Mmedical ~~E~~examination.

(911) Denial of claim for medical services.

The insurer must send notice of the denial to each provider of medical services, and health insurance as defined under ORS 731.162, 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.

(102) Payment of compensation.

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.

(113) Medical benefits and funeral expenses.

Compensation payable to a worker or the worker's beneficiaries while a claim is pending acceptance or denial does not include:

(a) ~~†~~The costs of medical benefits; or

(b) ~~burial~~The cost of final disposition of the body or funeral expenses.

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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0147 Worker Requested Medical Examination

(1) Eligibility.

The director ~~shall~~ will determine the worker's eligibility for a ~~W~~worker ~~R~~requested Mmedical ~~E~~examination (~~Exam~~) under ORS 656.325(1). The worker is eligible for an exam if:

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~~(a) the~~ 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

~~(b) the~~ The denial was based on one or more Independent Medical Examination reports with which the attending physician or authorized nurse practitioner ~~disagreed~~ did not concur.

(2) Request for Exam.

The worker must submit a request for the exam to the ~~director~~ division. 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 the is 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) Required documentation.

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 the worker's 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 the is claim. For the purpose of this rule, "Attending Physician" and "Independent Medical Examination" have the meanings defined in ~~OAR 436-010-0005~~ ORS 656.005(12)(b) and 436-010-0265(1), respectively.

(4) Penalty for failure to provide documentation.

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) Selection of physicians.

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:

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(a) The worker's or the worker's representative's response must be in writing, signed, and ~~received by~~ delivered to the director within ~~ten business~~ 14 days of the mailing date of providing the notice 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.

(76) Scheduling the exam.

The worker or the worker's ~~legal representative~~ attorney shall ~~shall~~ must 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 (65) of this rule. An unrepresented worker may consult with the ~~Injured Worker Ombudsman~~ for Injured Workers for assistance.

(87) Required medical records.

The insurer must send the physician the worker's complete medical and diagnostic record on ~~this~~ the claim and the original questions asked of the independent medical examination(s) physician(s) no later than 14 days ~~prior to~~ before 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~~ before the scheduled exam.

(98) Exam Questions.

The worker, or the worker's representative, shall ~~shall~~ must 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~~ before the scheduled date of the exam. An unrepresented worker may consult with the ~~Injured Worker Ombudsman~~ for Injured Workers for assistance.

(109) Physicians Response.

~~_~~ 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 (98) of this rule and send the report to the worker's ~~legal representative~~ attorney, if any, or the worker, and the insurer within ~~5 working~~ 14 days.

(110) Payment of physician.

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~~ must be delivered in accordance with OAR 436-010.

(121) Failure to attend exam.

If the worker ~~fails to~~ does not attend the scheduled ~~W~~ worker R requested ~~M~~ medical E exam, the insurer must pay the physician for the missed examination under OAR 436-009-

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0010(13). 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.

(1312) Reimbursement for services.

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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0150 Timely Payment of Compensation

(1) General.

Benefits are ~~deemed~~ considered 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, the weekend or legal holiday. Subsequent payments may revert back to the payment schedule in place ~~prior to~~ before the weekend or legal holiday.

(2) Holidays.

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 e~~ 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

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mourning, rejoicing or other special observance only when the Governor also appoints that day as a holiday.

(3) Withheld compensation.

Compensation withheld under ORS 656.268(13) and (14), and ORS 656.596(2), will not be considered late 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.

(34) Timely payment of temporary disability.

First payment of ~~time loss~~temporary disability compensation must be timely. ~~An insurer's performance is in compliance when 90 percent of payments are timely. The director may assess a penalty under OAR 436-060-0200 against an insurer falling~~that does not make the first payment of temporary disability under the timeframes of this section, or does not accurately report timeliness of first payment information ~~below these norms during any quarter.~~

~~(a) (4) Compensation withheld under ORS 656.268(13) and (14), and ORS 656.596(2), shall not be deemed untimely provided 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~~the first payment of temporary disability benefits ~~means payment has~~must been made no later than the 14th day after:

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

(~~b~~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;

(~~c~~C) The start of authorized vocational training under ORS 656.268(10), if the claim has previously been closed;

(~~d~~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~~E) The date of any ~~division~~director's order, including, but not limited to, a reconsideration order, ~~which that~~ orders payment of temporary disability. If 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~~F) The date of a notice of claim closure issued by the insurer that finds the worker entitled to temporary disability;

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- (~~g~~G) The date a notice of closure is set aside by a reconsideration order;
- (~~h~~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~~I) The date the ~~division~~director refers a claim to the insurer for processing under ORS 656.029;
- (~~j~~J) The date the ~~division~~director refers a noncomplying employer claim to an assigned claims agent under ORS 656.054;~~or~~
- (~~k~~K) The date a claim disposition is disapproved by the Worker’s Compensation Board or ~~Administrative Law Judge~~administrative law judge, if temporary disability benefits are otherwise due;
- (~~l~~L) The date the ~~division~~director designates a paying agent under ORS 656.307;
- (~~m~~M) The date a claim is reclassified from nondisabling to disabling, if temporary disability is due and payable; ~~and~~or
- (~~n~~N) The date an insurer voluntarily rescinds a denial of a disabling claim.

(b) Subsequent payments of temporary disability benefits must:~~(6)~~

~~(A) Temporary disability must be paid to within seven days of the date of payment at least once each 14 days, unless the employer is making payments under OAR 436-060-0020(1) and the payments are made concurrently with the payroll schedule of the employer; and-~~

(B) Include all benefits due for the period ending no more than seven days before the payment date;

~~When making payments as provided in 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) Timely payment of permanent disability.

(a) The first payment of ~~Permanent~~permanent disability must be paid no later than the 30th day after:

- (~~a~~A) The date of a notice of claim closure issued by the insurer;
- (~~b~~B) The date of any litigation order ~~which~~that orders payment of permanent total disability. Permanent total disability 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;

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- (eC) The date of any ~~division~~ director order, including, but not limited to, a reconsideration order, ~~which~~ that orders payment of compensation for permanent disability;
- (dD) The date any litigation order authorizing permanent partial disability becomes final;
- (eE) The date a claim disposition agreement is disapproved by the Workers' Compensation Board or ~~Administrative Law Judge~~ administrative law judge, if permanent disability benefits are otherwise due; or
- (fF) 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(42).
- (b) Subsequent payments of permanent disability must be made on a regular and predictable monthly schedule.
- (A) The insurer may adjust the monthly payment schedule, but must inform the beneficiary before making the adjustment.
- (B) No payment period may exceed one month without the director's approval.
- (8) Timely payment of fatal benefits.**
- (a) The first payment of fatal benefits under ORS 656.204 must be paid no later than the 30th day after:
- (aA) The date of a notice of acceptance issued by the insurer; or
- (bB) 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)~~ (b) Subsequent payments of permanent disability and fatal benefits are must be made on a regular and predictable monthly schedule. in monthly sequence.
- (A) The insurer may adjust the monthly payment dates schedule, but must inform the beneficiary prior to before making the adjustment.
- (B) No payment period shall may exceed one month without the division director's approval.
- (10)(a) Notice to worker regarding payments.**
- The insurer must provide an explanation in writing to the worker or beneficiary when the benefit amount, time period covered, or payment schedule changes, and must:
- (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 covered by for which the each payment of temporary disability benefits covers.

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~~(b) When issuing the initial payment of permanent disability or fatal benefits the insurer must n~~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 with the first payment of permanent disability of fatal benefits. 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) Maintenance of records.

The insurer must maintain records of compensation paid for each claim ~~where~~ in which benefits are due and payable.

(12) Request for reimbursement.

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) Claims disposition agreements.

Payment of a Any amounts due under a cClaim Disposition ~~disposition~~ Agreement agreement must be paid ~~made~~ no later than the 14th day after the Workers' Compensation Board or Administrative Law Judge administrative law judge ~~mails~~ provides notice of its approval under OAR 438-009-0028(1) ~~of the agreement to the parties~~, unless otherwise stated in the agreement.

(14) Claims under other jurisdictions.

~~Under ORS 656.126(6), w~~When a worker has a claim under the workers' compensation law of another state, territory, province or foreign nation for the same injury or occupational disease as the claim filed in Oregon:

(a) The worker is entitled to the full amount of compensation due under Oregon law,

(b) The total amount paid or awarded under the other jurisdiction's law must be credited against the compensation due under Oregon law,

(c) If -Oregon compensation is more than the compensation paid or awarded under another the other jurisdiction's 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.

(d) Upon learning that the worker has a claim under the jurisdiction of another workers' compensation law, the insurer must request written documentation of the amount paid or awarded to the worker.

(e) Payment under this section is due within 14 days of receipt of written documentation supporting the underpayment of Oregon compensation.

Statutory authority: ORS 656.704 and 656.726(4)

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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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0153 Electronic Payment of Compensation

(1) General.

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.

(a) The worker's consent must be obtained ~~prior to~~ before initiating electronic payments and may be written or verbal.

(b) The insurer must provide the worker a written confirmation when consent is obtained verbally.

(c) The worker may discontinue receiving electronic payments by notifying the insurer in writing.

(d) An employer making payments under OAR 436-060-0020(1) may assume the worker consents to having benefits paid through a direct deposit system if that is the method the employer usually uses to pay the worker's wages.

(32) Cardholder agreement for ATM or debit cards.

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~~ before or at the time the initial electronic payment is made.

(43) Availability of funds.

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: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0155 Penalty to Worker for Untimely Processing

(1) General.

~~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~~ If the insurer unreasonably delays or unreasonably refuses to pay compensation, attorney fees or costs, -or unreasonably delays acceptance or denial of a claim, the director may require the insurer to pay:

(a) A penalty of up to 25 percent of the amounts then due to the worker, determined by the matrix attached to these rules in Appendix "B". When there are no "amounts then due" upon which to assess a penalty, no penalty will be issued under this rule; and

(b) A fee to the worker's attorney under ORS 656.262(11) and OAR 436-001-0420.-

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~~(2) Requests for penalties and attorney fees under this section must be in writing, stating what benefits 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 OAR 436-001-0400 to 436-001-0440.~~

(2~~3~~) Violations.

For the purpose of this [rule, and the matrix attached to these rules in Appendix "B", a "violation" is:](#) ~~section, "violation" is either:~~

- (a) ~~The due date of 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) ~~The date of the last payment, of A~~ [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; or~~
- (c) [The date an acceptance or denial notice was due under OAR 436-060-0140\(3\).](#)

(3) Requests for penalties and attorney fees.

[Requests for penalties and attorney fees under this rule must be in writing, state what benefits have been delayed or remain unpaid, and be mailed or delivered to the division within 180 days of the alleged violation.](#)

(4) Required response from the insurer.

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.

- (a) [The response must include a reason for the delay, and any additional information or documentation requested by the director.](#)
- (b) [The response must be mailed or delivered to the division within 21 days of the mailing date of the ~~division~~director's inquiry letter;](#) ~~with~~
- (c) ~~copies~~ [Copies](#) of the response, including any attachments, [must be sent](#) simultaneously [sent](#) to the worker and the worker's attorney, ~~(if the worker is represented).~~

(5) Failure to respond.

~~If an~~ [the insurer fails to respond or meet the requirements of section \(3\), the director may assess an additional civil penalty](#) ~~provides an inadequate response (e.g. failing to answer specific questions or provide requested documents), assessment of a civil penalty may occur under OAR 436-060-0200.~~

~~In addition, 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.~~

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~~(56) -If the worker has not provided~~ 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 delay shall be considered unreasonable, unless the worker has provided insufficient information to assess a penalty, ~~the director~~. In such cases, a civil penalty may be assessed a civil penalty under OAR 436-060-0200.

(76) Proceedings where assessment and payment of penalties and fees are the sole issue.

The director will ~~has exclusive jurisdiction~~ only consider a penalty issue when ~~re~~ the assessment and payment of penalties and attorney fees described in this rule additional amounts described in ORS 656.262(11) is are the sole issue of any the proceedings between the parties.

(8) Proceedings before the Hearings Division.

The director will not issue an order assessing a penalty or attorney fee under this rule when the same parties have initiated proceedings before the Hearings Division.

(a) If the director receives a request for penalties and attorney fees under this rule, and is aware of proceedings between the parties before the Hearings Division, the director will refer the request to the Hearings Division.

(b) If a proceeding on any other issue is initiated before the Hearings Division of the Workers' Compensation Board between the same parties prior to the director issuing an order under this section, and the director is made aware of the proceeding, jurisdiction over the penalty proceeding before the director shall immediately rest with the Hearings Division and result in referral 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 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.~~

(98) Timely payment of penalties.

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. Failure to pay penalties in a timely manner will subject the insurer to civil penalties under OAR 436-060-0200.

(109) Dispute resolution.

To resolve a dispute by agreement, in which -the director has exclusive jurisdiction under section (7) of this rule, and the violation occurred within the last 180 days, the parties must submit a stipulation to the division for approval that specifies: Disputes regarding unreasonable delay or unreasonable refusal to pay compensation, 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 ORS 656.262(11) is the sole issue of a proceeding between the parties, and the

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~~violation(s) occurred within the last 180 days in accordance with section (3), then a stipulation must be submitted to the division for approval. The stipulation must specify:~~

- (a) The benefits 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.

(11) Any other agreements between the parties to pay a penalty or attorney fee must have a stipulation approved by the director to be acknowledged as a violation as it applies to the matrix in Appendix "B" of these rules.

~~(12)~~ Payment of the penalty is due within 14 days after the date the ~~division~~ director approves the stipulation, unless otherwise stated in the stipulation. Failure to pay penalties in a timely manner will 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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0160 Use of Sight Draft to Pay Compensation Prohibited

Insurers ~~shall~~ may not use a sight draft to pay any benefits or payments 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
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0170 Recovery of Overpayment of Benefits

(1) Benefits paid a worker.

An insurers may only recover overpayment of benefits paid to a worker as specified by ORS 656.268(14), unless authority is granted by an ~~Administrative Law Judge~~ administrative law judge or the Workers' Compensation Board.

(2) Benefits due a worker.

An insurers may recover an overpayment from any benefits currently due on any claim the worker has with that insurer. ~~The Insurers~~ insurer 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.

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(3) Permanent partial disability offsets.

When overpaid benefits are offset against monthly permanent partial disability award payments, the insurer must recover the benefits ~~recovery shall be~~ from the total amount of the award. The insurer must pay out ~~with the remainder of the award being paid out~~ at 4.35 times the temporary total disability rate, or at least ~~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(132) and (14), 656.704, and 656.726(4)
Hist: Amended 10/26/04 as WCD Admin. Order 04-064, eff. 1/1/05
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0180 Designation and Responsibility of a Paying Agent

(1) For the purpose of this rule:

- (a) "Compensable injury" means an accidental injury or damage to a prosthetic appliance, or an occupational disease arising out of and in the course of employment with any Oregon employer, and which requires medical services or results in disability or death.
- (b) "Exposure" means a specific incident or period during which a compensable injury may have occurred.
- (c) "Responsibility" means liability under the law for the acceptance and processing of a compensable claim.

(2) General.

The ~~division~~ director 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 the worker;
- (b) Which of more than one insurer of a certain employer is responsible for payment of compensation to a the 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) Own motion claims.

With the consent of the Workers' Compensation Board, ~~Own~~ own ~~Motion~~ motion claims under ORS 656.278(1) ~~are subject to the provisions of~~ this rule.

(4) Determination of compensability.

Upon learning of any of the ~~situations~~ issues 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.

- (a) 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

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information ~~without charge~~ pertinent to the injury without charge in order to expedite claim processing.

(b) 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.

(c) Copies of claims documents must be mailed under the timeframes established in OAR 436-060-0017(7).

~~(d) No~~ An insurer who ~~that~~ shares information in accordance with under this rule shall bears ~~any~~ no legal liability for disclosure of ~~the~~ such information.

(5) Notification of affected insurers.

Upon learning of any of the ~~situations~~ issues 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~~ that 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) Request for designation of a paying agent.

Upon deciding that the responsibility for an otherwise compensable injury cannot be determined, the insurer must request designation of a paying agent ~~by from writing to the division~~ director in writing and ~~send~~ mailing a copy of the request to the worker and the worker's representative, if any.

~~(a) The insurer may not request shall not be contained in or attached the request to, or include the request in,~~ 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.

(b) ~~The~~ Such a request, or agreement to designation of a paying agent, is not an admission that the insurer is responsible for the compensable injury, ~~injury is compensably related to that insurer's claim;~~ it is solely an assertion that the injury is compensable against a subject Oregon employer.

(c) The insurer's written request ~~to the division~~ must contain the following information:

- ~~(a)~~ A Identification of the compensable injury ~~(ies)~~ ies or occupational diseases;
- ~~(b)~~ B That the insurer is requesting designation of a paying agent under ORS 656.307;
- ~~(c)~~ C That the insurer acknowledges the ~~injury~~ claim is otherwise compensable;
- ~~(d)~~ D That responsibility is the only issue;

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(eE) Identification of the specific claims or periods of exposures involved by:

(Ai) Employer;

(Bii) Insurer;

(Ciii) Date of injury or specific period of exposure; and

(Diy) Claim number, if assigned;

(fF) Acknowledgment that medical reports and other material pertinent to the injury have been provided to the other parties; and

(gG) Confirmation the worker has been advised of the actions being taken on the worker's claim.

(7d) The ~~division~~ director will not designate a paying agent when:

(A) It has not been determined if there remains an issue of whether the injury is compensable against a subject Oregon employer; or

(B) An insurer included in the question of responsibility opposes designation of a paying agent because it has received no claim; or

(C) if the ~~The~~ 60 day appeal period of a denial has expired without and:

(i) a ~~No~~ request for hearing had being been received by the Board; or

(ii) the ~~division~~ receiving a ~~No~~ request for a designation of paying agent order had been received by the director; or if an insurer included in the question of responsibility opposes designation of a paying agent because it has received no claim.

(8) Failure to respond to request for clarification.

When notified by the ~~division~~ director 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, the other 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), the director may assess a civil penalty ~~will be assessed under~~ OAR 436-060-0200.

(9) Insurer responsibilities.

Insurers receiving notice from the ~~division~~ director of a worker's request for designation of a paying agent must immediately process the request in accordance with sections (4) through (6) of this rule.

(10) Factors for designation.

Upon receipt of written acknowledgment from the insurers that the only issue is responsibility for an otherwise compensable injury claim, the ~~division~~ director will issue an order designating a paying agent under ORS 656.307. The ~~division~~ director will designate the insurer with the lowest compensation considering the following factors:

(a) The claim with the lowest temporary total disability rate.

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(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 o“Own Mmotion” jurisdiction, ~~the Own Motion~~hat claim, even if it is not the claim with the lowest temporary total disability rate.

(f) If more than one claim is under “Own Mmotion” jurisdiction, the Own Mmotion claim with the lowest temporary total disability rate.

(11) Referral to the Worker’s Compensation Board.

By copy of its order, the ~~division~~director 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) Responsibilities of designated paying agent.

-The designated paying agent must process the claim as an accepted claim through claim closure under OAR 436-030-0015 ~~(9)~~ unless it is relieved of the responsibility by an order of the Aadministrative Llaw Jjudge or resolution through mediation or arbitration under ORS 656.307(6).

(a) The parties to an order under this section ~~shall~~may 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.

(b) 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.

(c) The Consumer and Business Services Fund ~~shall not be~~is not obligated when one party declines to participate in a legitimate settlement conference under an ORS 656.307 order.

(d) 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) Change in compensability or claims status.

After a paying agent is designated, if any of the insurers determine compensability ~~is or~~ willmay be an issue at hearing, they insurer must notify the division.

(a) 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.

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(b) 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~~ director ~~shall~~ will 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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
 See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0190 Monetary Adjustments ~~Among~~ among Parties and Department of Consumer and Business Services

(1) General.

An order of the director under ORS 656.307 and OAR 436-060-0180 applies only to the period ~~prior to~~ before the order of the ~~Administrative Law Judge~~ administrative law judge determining the responsible paying party. Payment of compensation made ~~thereafter~~ shall ~~the~~ order may not be recovered from the Consumer and Business Services Fund, unless the director concludes payment was made before the ~~Administrative Law Judge~~ administrative law judge's order was received by the paying agent designated under OAR 436-060-0180. ~~Any monetary adjustment necessary a~~ After the Administrative Law Judge administrative law judge's order, any necessary monetary adjustments ~~shall~~ must be ~~handled~~ made under OAR 436-060-0195.

(2) Determination of benefits paid.

-When all litigation on the issue of responsibility is final, the insurer ultimately held to be responsible must, ~~prior to~~ before paying any compensation, contact any nonresponsible insurer to ~~learn~~ determine 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 contact. 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) Reimbursement of nonresponsible insurers.

The responsible insurer must reimburse any nonresponsible insurers for compensation the nonresponsible insurer paid ~~which~~ that the responsible insurer is responsible for, but has not already paid, within 30 days of receiving ~~sufficient~~ enough 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~~ that results in duplicate payment to the worker, medical providers or others as a result of failing to contact the nonresponsible insurer ~~shall~~ does not release the responsible insurer from the requirement to reimburse any nonresponsible insurers for its costs.

(4) Direction of unresolved adjustments.

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The ~~division~~director shall ~~may~~ direct any necessary monetary adjustment between the parties involved which ~~that~~ is not otherwise ordered by the ~~Administrative~~administrative Law ~~law~~ Judge ~~judge~~ or voluntarily resolved by the parties. ~~,-~~ The director but shall ~~will~~ 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) of this rule. Any insurer that fails to make monetary adjustments within 30 days of an order by the ~~division~~director will ~~may be~~ 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~~is recoverable from the Consumer and Business Services Fund when such compensation is not reimbursed to the nonresponsible insurer by the responsible insurer.

(5) Unnecessary costs.

When the ~~division~~director determines improper or untimely claim processing by the designated paying agent has resulted in unnecessary costs, the ~~division~~director 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
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0195 Miscellaneous Monetary Adjustments a Among Insurers

(1) General.

The director may order monetary adjustments between insurers ~~under authority provided by ORS 656.726(4) and 656.202~~ when ~~re~~ a claimant worker 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.~~

~~(a) (2)~~ When any litigation on the issues in question is final, insurers must make any necessary monetary adjustments ~~among~~between 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~~enough information to ~~adequately~~ determine the benefits paid and the relationship to the condition(s) involved.

(b) Any balance due after making such adjustments must be paid in a timely manner to the worker, medical providers and other parties under OAR 436-009 and 436-060-0150.

(c) Any failure to obtain reimbursement from an insurer under this rule is not recoverable from the Consumer and Business Services Fund.

(3) Obligation to process claims.

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The ~~division~~director may direct any necessary monetary adjustment between parties, but ~~shall~~will not order an insurer to pay compensation over and beyond that required by law, as it relates to the insurer's claim, except when ~~re~~re an insurer unduly compensates a ~~claimant~~worker 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~~director 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, the other insurers involved and other interested parties within 21 days of the mailing date of the notification.

(4) Failure to make adjustments.

Failure to respond to the ~~division~~director's inquiries or make monetary adjustments within 30 days of an order by the ~~division~~director will subject the insurer to civil penalties under OAR 436-060-0200.

(5) Unnecessary costs.

When the ~~division~~director determines improper or untimely claim processing by an insurer resulted in unnecessary costs, the ~~division~~director 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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0200 Assessment of Civil Penalties

(1) Penalties for inducing failure to report claims.

The director ~~through the division and under ORS 656.745 shall~~may assess a civil penalty against an employer or insurer ~~who~~that intentionally or repeatedly induces ~~claimant~~workers ~~for compensation~~ to fail to report accidental injuries, causes employees to collect accidental injury claims as off-the-job injury claims, persuades ~~claimant~~workers to accept less than the compensation due or makes it necessary for ~~claimant~~workers to resort to proceedings against the employer to secure compensation due.

(~~2~~a) A penalty under this section (~~1~~) will only be assessed after all litigation on the matter has become final by operation of the law.

(~~b~~b) For the purpose of this section (~~1~~):

(~~a~~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~~B) "Repeatedly" means more than once in any twelve month period.

(3) Penalties for failure to comply with statutes, rules and orders.

~~Under ORS 656.745, t~~The director may assess a civil penalty against an employer or insurer ~~who~~that fails to comply with the rules and orders of the director regarding reports or other

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requirements necessary to carry out the purposes of the ~~Workers' Compensation Law~~ [ORS chapter 656](#).

(4) Penalties for failure to meet timeframe requirements.

~~The director may assess a civil penalty of up to \$2,000 against an~~ [An-an](#) employer or insurer ~~that failing~~ to meet the time-frame requirements set forth in OAR 436-060-0010, 436-060-0017, 436-060-0018, 436-060-0030, 436-060-0060, [436-060-0140](#), 436-060-0147, 436-060-0155 and 436-060-0180 ~~may be assessed a civil penalty up to \$2,000.~~

(5) Penalties for use of sight draft to pay compensation.

~~The director may assess a civil penalty of up to \$2,000 against an~~ [An-an](#) insurer ~~who that~~ willfully violates OAR 436-060-0160 ~~shall be assessed a civil penalty of up to \$2,000.~~

(6) Penalties for inaccurate reporting of first payment timeliness.

~~The director may assess a civil penalty of \$500 against an~~ [An-an](#) insurer that does not accurately report timeliness of first payment information to the division, ~~may be assessed a civil penalty of \$500 for reporting inaccurate information plus \$50 for each violation, or \$10,000 in the aggregate for all violations within any three month period. For the purposes of this section, a violation consists of each situation where~~ [in which](#) a first payment was reported to have been made timely, but was found upon audit to have actually been late.

(7) Penalties for failure to comply with claims processing requirements.

Notwithstanding section (3) of this rule, ~~the director may assess civil penalties of up to \$2,000 against an employer or insurer for each violation of who does not comply with the claims processing requirements of ORS chapter 656, OAR chapter 436 and rules and orders of the director relating thereto.~~

~~(a) Penalties assessed for all violations will not exceed~~ [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.](#)

~~(b) For the purpose of section, the 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, and 656.331.~~

(8) Penalties for misrepresentation to obtain claims records.

~~The director may assess a civil penalty of \$1,000 against a~~ [Any](#) employer or insurer that misrepresents ~~themselves~~ [itself](#) 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](#);

~~(a) the director may s~~ [uspend or revoke](#) an employer's or insurer's access to workers' compensation claims records for such time as the director may determine; ~~or~~;

~~(b) Any other person's access to workers' compensation claims records~~ [Any other person](#) ~~if the director~~ [determined](#) to ~~they~~ [have](#) misrepresented themselves or ~~who~~

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uses used records in a manner contrary to these rules. ~~shall 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) Performance Audits.

~~Insurer performance data is reviewed every quarter based on reports submitted by the insurer during the previous calendar quarter. Insurers will be subject to periodic performance audits. Civil penalties will may be issued for each of the performance areas where the insurer's performance percentages falls below the acceptable standards of performance as set forth in these rules and orders of the director. 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."~~

(10) Considerations for assessing penalties.

In arriving at the amount of penalty under this rule, the director 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

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

(12)11) Penalty to worker's attorney for failure to cooperate with insurer's investigation.

~~Under ORS 656.262(14), The director may assess a civil penalty not to exceed \$1,000 against an injured worker's attorney that is unreasonably not unwilling or unavailable to participate in an insurer's interview as required by ORS 656.262(14) 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 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0400 Penalty and Attorney Fee for Untimely Payment of Disputed Claims Settlement

(1) Right to request penalties and attorney fees.

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) Requirements for requests.

Requests for penalties and attorney fees under this ~~section~~ rule must be in writing, state what payments were delayed or remain unpaid, and be 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) Required response from the insurer.

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.

(a) The response must include any information or documentation requested by the director.

(b) The response must be mailed or delivered to the division within 14 days of the date of the ~~division~~ director's inquiry letter; and

(c) ~~with e~~Copies of the response, including any attachments, must be sent simultaneously to the worker and the worker's attorney, if the worker is ~~(if~~ represented).

(4) Failure to respond.

If ~~an~~ the insurer fails to meet the requirements of section (3) of this rule, the director may assess additional ~~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.~~

(5) Penalty and fee amounts.

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 "DC."

(6) Timely payment of penalties.

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) General.

When an insurer elects to pay supplemental disability due a worker with multiple jobs at the time of injury, the director shall ~~will~~ 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 ~~the third party administrator~~ service company, if applicable.

(2) Requests for reimbursement.

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, ~~s~~ Social ~~s~~ 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~~ policy 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, including start and end dates. ~~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) Administrative fee.

In addition to the supplemental disability reimbursement, the ~~division~~ director shall ~~calculate and the will pay the~~ insurer shall be paid an administrative fee based on the annual claim processing administrative cost factor, as published in Bulletin 316.

(4) Repayment of invalid or incorrect payments.

The director may require the insurer to repay reimbursements made for invalid or incorrect payments.

(a) The director may pPeriodically ~~the division will~~ audit the ~~physical~~ insurer's files of the ~~insurer responsible for processing the claim~~ to validate the amount reimbursed.

(b) Invalid amounts include, but are not limited to ~~Reimbursement will be disallowed and repayment will be required if, upon such audit, it is found:~~

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(~~a~~A) Payments exceeding statutory amounts due the insurer, excluding reasonable overpayments, as determined by the ~~division~~ director;

(~~b~~B) Compensation ~~has been~~ paid as a result of untimely or inaccurate claims processing; ~~or~~

(~~c~~C) Payments of compensation ~~have~~ that were not been documented, as required by OAR 436-050; or

(D) Amounts in a third-party recovery that result in overpayment.

(5) Benefits due workers of a noncomplying employer.

Supplemental disability benefits due subject workers of an noncomplying 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) Claims disposition agreements and stipulated claims settlements.

Claim ~~d~~Dispositions agreements or ~~S~~stipulated- claims ~~S~~settlements, under ORS 656.236 or 656.289, ~~which that~~ include amounts for supplemental disability benefits due to multiple jobs, are not eligible to receive reimbursement from the Workers' Benefit Fund unless they receive written confirmation from the director made with the prior before the disposition or settlement is written approved at by the Worker's Compensation Board. of the director.

(a) To receive written confirmation of a proposed disposition or settlement, the insurer must submit a request to the division. The request for written confirmation ~~Requests for written approval of proposed dispositions~~ must include:

(A) A copy of the proposed disposition or settlement that specifies the exact proposed 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~~ confirm 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: ORS 656.210, 656.704, and 656.726(4)

Hist: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-060-0510 Reimbursement of Permanent Total Disability Benefits from the Workers' Benefit Fund

(1) General.

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) Requirements for requests.

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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) Monies due under Retroactive or Reopened Claims Programs.

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: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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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

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APPENDIX "DC"

436-060-0400 Matrix for Assessing Penalties

SETTLEMENT PROCEEDS ALLOCATED TO
CLAIMANT WORKER/ATTORNEY

NUMBER OF DAYS LATE	PENALTY ASSESSMENTS AND ATTORNEY FEES
1-2	5%
3-7	10%
8-14	15%
15-30	20%
31+	25%