Industry Notice

Nov. 8, 2023

To: Workers' compensation insurers, self-insured employers, service companies, injured workers, attorneys, health care providers, and other interested parties

Subject: House Bill 4138 (2022) changes in claim processing starting Jan. 1, 2024

House Bill (HB) 4138 amends Oregon workers' compensation laws that relate to temporary disability, medically stationary status, and recovery of overpayments. These law changes apply to all claims that exist or arise on or after Jan. 1, 2024, regardless of the date of injury or the date on which the claim is filed.

The Workers' Compensation Division ("division") conducted rulemaking to implement the bill, adopting rules effective Jan. 1, 2024.

This notice provides a brief summary of the major claim processing changes in the enacted bill and adopted rules. However, interested parties are advised to review the full text of the bill which can be found here. A full summary of the rule changes related to HB 4138 can be found here.

Temporary disability

- An insurer or self-insured employer may not end temporary disability benefits until written notice has been mailed or delivered to the worker and the worker's attorney. The notice must explain why temporary disability is no longer due and payable. See ORS 656.262(4)(j)(A), OAR 436-060-0015(7), OAR 436-120-0443(14).

- ORS 656.262(4)(g)(A) specifies:
  - How far back temporary disability may be retroactively authorized
  - Temporary disability is not due and payable after the attending physician or nurse practitioner ceases to authorize it
  - Temporary disability is not due and payable for any period not authorized by the attending physician or nurse practitioner

  ORS 656.262(4)(g)(B) states when ORS 656.262(4)(g)(A) does not apply.

- The time frame that an attending physician or nurse practitioner may retroactively authorize payment of temporary disability is extended from 14 days to 45 days. ORS 656.262(4)(g) and (j) specify some exceptions to the 45-day limit.

Medically stationary status

- An attending physician or nurse practitioner may not retroactively determine a worker medically stationary more than 60 days prior to the date of the determination. See ORS 656.268(1)(a).

- An insurer or self-insured employer must mail or deliver written notice to a worker and the worker's attorney within seven days following receipt of information that the worker is medically stationary. See ORS 656.268(1)(a), OAR 436-060-0015(8), OAR 436-030-0015(14).

- If the medically stationary date under OAR 436-030-0035(1), (4), (5), or (6) is more than 60 days prior to the date of the determination, the medically stationary date is the 60th day prior to the date of the determination. See OAR 436-030-0035(9).

- For claim closures following an authorized training plan under OAR 436-120, if the worker is medically stationary, there must be a current (within 60 days before closure) determination of medically stationary status. See OAR 436-030-0020(14).

Overpayment recovery

- An insurer or self-insured employer may not recover an overpayment from a worker's permanent partial disability compensation for overpayments, offsets, or credits of wage loss in an amount that exceeds 50 percent of the total compensation awarded to the worker. See ORS 656.268(16)(a).

- An insurer or self-insured employer may not declare an overpayment of any compensation that was paid more than two years prior to the date of the declaration. See ORS 656.268(16)(b).

If you have questions about this notice, contact the division at 800-452-0288 (toll-free) or email workcomp.questions@dcbs.oregon.gov.

Sally Coen, Administrator
Workers' Compensation Division

Distribution: GovDelivery

Enrolled
House Bill 4138

Sponsored by Representative GRAYBER, Senator JAMA; Representatives ALONSO LEON, CAMPOS, DEXTER, HUDSON, KROPF, MEEK, NOSSE, POWER, RUIZ, SANCHEZ, VALDERRAMA, WITT, Senators LIEBER, MANNING JR (Presession filed.)

CHAPTER .....

AN ACT

Relating to workers' compensation benefits; creating new provisions; and amending ORS 656.262 and 656.268.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 656.262 is amended to read:

656.262. (1) Processing of claims and providing compensation for a worker shall be the responsibility of the insurer or self-insured employer. All employers shall assist their insurers in processing claims as required in this chapter.

(2) The compensation due under this chapter shall be paid periodically, promptly and directly to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, except where the right to compensation is denied by the insurer or self-insured employer.

(3)(a) Employers shall, immediately and not later than five days after notice or knowledge of any claims or accidents which may result in a compensable injury claim, report the same to their insurer. The report shall include:

(A) The date, time, cause and nature of the accident and injuries.

(B) Whether the accident arose out of and in the course of employment.

(C) Whether the employer recommends or opposes acceptance of the claim, and the reasons therefor.

(D) The name and address of any health insurance provider for the injured worker.

(E) Any other details the insurer may require.

(b) Failure to so report subjects the offending employer to a charge for reimbursing the insurer for any penalty the insurer is required to pay under subsection (11) of this section because of such failure. As used in this subsection, "health insurance" has the meaning for that term provided in ORS 731.162.

(4)(a) The first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim and of the worker's disability, if the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 authorizes the payment of temporary disability compensation. Thereafter, temporary disability compensation shall be paid at least once each two weeks, except where the Director of the Department of Consumer and Business Services determines that payment in installments should be made at some other interval. The director may by rule convert monthly benefit schedules to weekly or other periodic schedules.

(b) Notwithstanding any other provision of this chapter, if a self-insured employer pays to an injured worker who becomes disabled the same wage at the same pay interval that the worker received at the time of injury, such payment shall be deemed timely payment of temporary disability payments pursuant to ORS 656.210 and 656.212 during the time the wage payments are made.

(c) Notwithstanding any other provision of this chapter, when the holder of a public office is injured in the course and scope of that public office, full official salary paid to the holder of that public office shall be deemed timely payment of temporary disability payments pursuant to ORS 656.210 and 656.212 during the time the wage payments are made. As used in this subsection, "public office" has the meaning for that term provided in ORS 260.005.

(d) Temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 verification of the worker's inability to work resulting from the claimed injury or disease and the physician or nurse practitioner cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control.

(e) If a worker fails to appear at an appointment with the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245, the insurer or self-insured employer shall notify the worker by certified mail that temporary disability benefits may be suspended after the worker fails to appear at a rescheduled appointment. If the worker fails to appear at a rescheduled appointment, the insurer or self-insured employer may suspend payment of temporary disability benefits to the worker until the worker appears at a subsequent rescheduled appointment.

(f) If the insurer or self-insured employer has requested and failed to receive from the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 verification of the worker's inability to work resulting from the claimed injury or disease, medical services provided by the attending physician or nurse practitioner are not compensable until the attending physician or nurse practitioner submits such verification.

(g)**(A)** Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 ceases to authorize temporary disability or for any period of time not authorized by the attending physician or nurse practitioner. No authorization of temporary disability compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than [*14*] **45** days prior to its issuance.

(B) Subparagraph (A) of this paragraph does not apply:

(i) During periods in which there is a denial under the jurisdiction of the Workers' Compensation Board that affects the worker's ability to obtain authorization of temporary disability;

(ii) During periods in which there is a dispute over the identity of, or treatment by, an attending physician or nurse practitioner that affects the worker's ability to obtain authorization of temporary disability; or

(iii) When notice has not been given pursuant to paragraph (j) of this subsection.

(h) The worker's disability may be authorized only by a person described in ORS 656.005 (12)(b)(B) or 656.245 for the period of time permitted by those sections. The insurer or self-insured employer may unilaterally suspend payment of temporary disability benefits to the worker at the expiration of the period until temporary disability is reauthorized by an attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245.

(i) The insurer or self-insured employer may unilaterally suspend payment of all compensation to a worker enrolled in a managed care organization if the worker continues to seek care from an attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 that is not authorized by the managed care organization more than seven days after the mailing of notice by the insurer or self-insured employer.

(j)(A) The insurer or self-insured employer may not end temporary disability benefits until written notice has been mailed or delivered to the worker and the worker's attorney, if the worker is represented. The notice must state the reason that temporary disability benefits are no longer due and payable.

(B) The worker's attending physician or nurse practitioner may retroactively authorize temporary disability for up to 45 days prior to the date of the notice.

(C) If the notice required under subparagraph (A) of this paragraph is given more than 45 days after the worker was no longer eligible for benefits, the attending physician or nurse practitioner may retroactively authorize temporary disability back to the date on which benefits were no longer due and payable, provided the authorization is made within 30 days following the earlier of the date of mailing or delivery of the written notice that the eligibility ended to the worker and the worker's attorney, if the worker is represented.

(5)(a) Payment of compensation under subsection (4) of this section or payment, in amounts per claim not to exceed the maximum amount established annually by the Director of the Department of Consumer and Business Services, for medical services for nondisabling claims, may be made by the subject employer if the employer so chooses. The making of such payments does not constitute a waiver or transfer of the insurer's duty to determine entitlement to benefits. If the employer chooses to make such payment, the employer shall report the injury to the insurer in the same manner that other injuries are reported. However, an insurer shall not modify an employer's experience rating or otherwise make charges against the employer for any medical expenses paid by the employer pursuant to this subsection.

(b) To establish the maximum amount an employer may pay for medical services for nondisabling claims under paragraph (a) of this subsection, the director shall use $1,500 as the base compensation amount and shall adjust the base compensation amount annually to reflect changes in the United States City Average Consumer Price Index for All Urban Consumers for Medical Care for July of each year as published by the Bureau of Labor Statistics of the United States Department of Labor. The adjustment shall be rounded to the nearest multiple of $100.

(c) The adjusted amount established under paragraph (b) of this subsection shall be effective on January 1 following the establishment of the amount and shall apply to claims with a date of injury on or after the effective date of the adjusted amount.

(6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke acceptance except as provided in this section. The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured employer must prove, by a preponderance of the evidence, that the claim is not compensable or that the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are payable from the date any such benefits were terminated under the denial. Except as provided in ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not

include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer a copy of the notice of acceptance.

(b) The notice of acceptance shall:

(A) Specify what conditions are compensable.

(B) Advise the claimant whether the claim is considered disabling or nondisabling.

(C) Inform the claimant of the Expedited Claim Service and of the hearing and aggravation rights concerning nondisabling injuries, including the right to object to a decision that the injury of the claimant is nondisabling by requesting reclassification pursuant to ORS 656.277.

(D) Inform the claimant of employment reinstatement rights and responsibilities under ORS chapter 659A.

(E) Inform the claimant of assistance available to employers and workers from the Reemployment Assistance Program under ORS 656.622.

(F) Be modified by the insurer or self-insured employer from time to time as medical or other information changes a previously issued notice of acceptance.

(c) An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005 (7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition.

(d) An injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The insurer or self-insured employer has 60 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. A worker who fails to comply with the communication requirements of this paragraph or ORS 656.267 may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

(7)(a) After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical or omitted condition claims properly initiated pursuant to ORS 656.267 shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the insurer or self-insured employer receives written notice of such claims. A worker who fails to comply with the communication requirements of subsection (6) of this section or ORS 656.267 may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer.

(b) Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed.

(c) When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. The procedures specified in subsection (6)(d) of this section apply to this notice. Any objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition.

(8) The assigned claims agent in processing claims under ORS 656.054 shall send notice of acceptance or denial to the noncomplying employer.

(9) If an insurer or any other duly authorized agent of the employer for such purpose, on record with the Director of the Department of Consumer and Business Services denies a claim for compensation, written notice of such denial, stating the reason for the denial, and informing the worker of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the

claimant. A copy of the notice of denial shall be mailed to the director and to the employer by the insurer. The worker may request a hearing pursuant to ORS 656.319.

(10) Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a notice of closure, reconsideration order or litigation order, or the failure to appeal or seek review of such an order or notice of closure, shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted.

(11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees assessed under this section. The fees assessed by the director, an Administrative Law Judge, the board or the court under this section shall be reasonable attorney fees. In assessing fees, the director, an Administrative Law Judge, the board or the court shall consider the proportionate benefit to the injured worker. The board shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed $4,000 absent a showing of extraordinary circumstances. The maximum attorney fee awarded under this paragraph shall be adjusted annually on July 1 by the same percentage increase as made to the average weekly wage defined in ORS 656.211, if any. Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount and attorney fees described in this subsection. The action of the director and the review of the action taken by the director shall be subject to review under ORS 656.704.

(b) When the director does not have exclusive jurisdiction over proceedings regarding the assessment and payment of the additional amount and attorney fees described in this subsection, the provisions of this subsection shall apply in the other proceeding.

(12)(a) If payment is due on a disputed claim settlement authorized by ORS 656.289 and the insurer or self-insured employer has failed to make the payment in accordance with the requirements specified in the disputed claim settlement, the claimant or the claimant's attorney shall clearly notify the insurer or self-insured employer in writing that the payment is past due. If the required payment is not made within five business days after receipt of the notice by the insurer or self-insured employer, the director may assess a penalty and attorney fee in accordance with a matrix adopted by the director by rule.

(b) The director shall adopt by rule a matrix for the assessment of the penalties and attorney fees authorized under this subsection. The matrix shall provide for penalties based on a percentage of the settlement proceeds allocated to the claimant and for attorney fees based on a percentage of the settlement proceeds allocated to the claimant's attorney as an attorney fee.

(13) The insurer may authorize an employer to pay compensation to injured workers and shall reimburse employers for compensation so paid.

(14)(a) Injured workers have the duty to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers shall submit to and shall fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. Injured workers who are represented by an attorney shall have the right to have the attorney present during any personal or telephonic interview or deposition. If the injured worker is represented by an attorney, the insurer or self-insured employer shall pay the attorney a reasonable attorney fee based upon an hourly rate for actual time spent during the personal or telephonic interview or deposition. After consultation with the Board of Governors of the Oregon State Bar, the Workers' Compensation Board shall adopt rules for the establishment, assessment and enforcement of an hourly attorney fee rate specified in this subsection.

(b) If the attorney is not willing or available to participate in an interview at a time reasonably chosen by the insurer or self-insured employer within 14 days of the request for interview and the insurer or self-insured employer has cause to believe that the attorney's unwillingness or unavailability is unreasonable and is preventing the worker from complying within 14 days of the request for interview, the insurer or self-insured employer shall notify the director. If the director determines that the attorney's unwillingness or unavailability is unreasonable, the director shall assess a civil penalty against the attorney of not more than $1,000.

(15) If the director finds that a worker fails to reasonably cooperate with an investigation involving an initial claim to establish a compensable injury or an aggravation claim to reopen the claim for a worsened condition, the director shall suspend all or part of the payment of compensation after notice to the worker. If the worker does not cooperate for an additional 30 days after the notice, the insurer or self-insured employer may deny the claim because of the worker's failure to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim within 60 days is suspended during the time of the worker's noncooperation. After such a denial, the worker shall not be granted a hearing or other proceeding under this chapter on the merits of the claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291 that the worker fully and completely cooperated with the investigation, that the worker failed to cooperate for reasons beyond the worker's control or that the investigative demands were unreasonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Administrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investigative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order the reinstatement of interim compensation if appropriate and remand the claim to the insurer or self-insured employer to accept or deny the claim.

(16) In accordance with ORS 656.283 (3), the Administrative Law Judge assigned a request for hearing for a claim for compensation involving more than one potentially responsible employer or insurer may specify what is required of an injured worker to reasonably cooperate with the investigation of the claim as required by subsection (14) of this section.

SECTION 2. ORS 656.262, as amended by section 1, chapter 47, Oregon Laws 2021, is amended to read:

656.262. (1) Processing of claims and providing compensation for a worker shall be the responsibility of the insurer or self-insured employer. All employers shall assist their insurers in processing claims as required in this chapter.

(2) The compensation due under this chapter shall be paid periodically, promptly and directly to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, except where the right to compensation is denied by the insurer or self-insured employer.

(3)(a) Employers shall, immediately and not later than five days after notice or knowledge of any claims or accidents which may result in a compensable injury claim, report the same to their insurer. The report shall include:

(A) The date, time, cause and nature of the accident and injuries.

(B) Whether the accident arose out of and in the course of employment.

(C) Whether the employer recommends or opposes acceptance of the claim, and the reasons therefor.

(D) The name and address of any health insurance provider for the injured worker.

(E) Any other details the insurer may require.

(b) Failure to so report subjects the offending employer to a charge for reimbursing the insurer for any penalty the insurer is required to pay under subsection (11) of this section because of such failure. As used in this subsection, "health insurance" has the meaning for that term provided in ORS 731.162.

(4)(a) The first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim and of the worker's disability, if the attending physician or nurse practitioner authorized to provide compensable medical

services under ORS 656.245 authorizes the payment of temporary disability compensation. Thereafter, temporary disability compensation shall be paid at least once each two weeks, except where the Director of the Department of Consumer and Business Services determines that payment in installments should be made at some other interval. The director may by rule convert monthly benefit schedules to weekly or other periodic schedules.

(b) Notwithstanding any other provision of this chapter, if a self-insured employer pays to an injured worker who becomes disabled the same wage at the same pay interval that the worker received at the time of injury, such payment shall be deemed timely payment of temporary disability payments pursuant to ORS 656.210 and 656.212 during the time the wage payments are made.

(c) Notwithstanding any other provision of this chapter, when the holder of a public office is injured in the course and scope of that public office, full official salary paid to the holder of that public office shall be deemed timely payment of temporary disability payments pursuant to ORS 656.210 and 656.212 during the time the wage payments are made. As used in this subsection, "public office" has the meaning for that term provided in ORS 260.005.

(d) Temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 verification of the worker's inability to work resulting from the claimed injury or disease and the physician or nurse practitioner cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control.

(e) If a worker fails to appear at an appointment with the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245, the insurer or self-insured employer shall notify the worker by certified mail that temporary disability benefits may be suspended after the worker fails to appear at a rescheduled appointment. If the worker fails to appear at a rescheduled appointment, the insurer or self-insured employer may suspend payment of temporary disability benefits to the worker until the worker appears at a subsequent rescheduled appointment.

(f) If the insurer or self-insured employer has requested and failed to receive from the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 verification of the worker's inability to work resulting from the claimed injury or disease, medical services provided by the attending physician or nurse practitioner are not compensable until the attending physician or nurse practitioner submits such verification.

(g)**(A)** Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 ceases to authorize temporary disability or for any period of time not authorized by the attending physician or nurse practitioner. No authorization of temporary disability compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than [*14*] **45** days prior to its issuance.

(B) Subparagraph (A) of this paragraph does not apply:

(i) During periods in which there is a denial under the jurisdiction of the Workers' Compensation Board that affects the worker's ability to obtain authorization of temporary disability;

(ii) During periods in which there is a dispute over the identity of, or treatment by, an attending physician or nurse practitioner that affects the worker's ability to obtain authorization of temporary disability; or

(iii) When notice has not been given pursuant to paragraph (j) of this subsection.

(h) The worker's disability may be authorized only by a person described in ORS 656.005 (12)(b)(B) or 656.245 for the period of time permitted by those sections. The insurer or self-insured employer may unilaterally suspend payment of temporary disability benefits to the worker at the expiration of the period until temporary disability is reauthorized by an attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245.

(i) The insurer or self-insured employer may unilaterally suspend payment of all compensation to a worker enrolled in a managed care organization if the worker continues to seek care from an attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 that is not authorized by the managed care organization more than seven days after the mailing of notice by the insurer or self-insured employer.

(j)(A) The insurer or self-insured employer may not end temporary disability benefits until written notice has been mailed or delivered to the worker and the worker's attorney, if the worker is represented. The notice must state the reason that temporary disability benefits are no longer due and payable.

(B) The worker's attending physician or nurse practitioner may retroactively authorize temporary disability for up to 45 days prior to the date of the notice.

(C) If the notice required under subparagraph (A) of this paragraph is given more than 45 days after the worker was no longer eligible for benefits, the attending physician or nurse practitioner may retroactively authorize temporary disability back to the date on which benefits were no longer due and payable, provided the authorization is made within 30 days following the earlier of the date of mailing or delivery of the written notice that the eligibility ended to the worker and the worker's attorney, if the worker is represented.

(5)(a) Payment of compensation under subsection (4) of this section or payment, in amounts per claim not to exceed the maximum amount established annually by the Director of the Department of Consumer and Business Services, for medical services for nondisabling claims, may be made by the subject employer if the employer so chooses. The making of such payments does not constitute a waiver or transfer of the insurer's duty to determine entitlement to benefits. If the employer chooses to make such payment, the employer shall report the injury to the insurer in the same manner that other injuries are reported. However, an insurer shall not modify an employer's experience rating or otherwise make charges against the employer for any medical expenses paid by the employer pursuant to this subsection.

(b) To establish the maximum amount an employer may pay for medical services for nondisabling claims under paragraph (a) of this subsection, the director shall use $1,500 as the base compensation amount and shall adjust the base compensation amount annually to reflect changes in the United States City Average Consumer Price Index for All Urban Consumers for Medical Care for July of each year as published by the Bureau of Labor Statistics of the United States Department of Labor. The adjustment shall be rounded to the nearest multiple of $100.

(c) The adjusted amount established under paragraph (b) of this subsection shall be effective on January 1 following the establishment of the amount and shall apply to claims with a date of injury on or after the effective date of the adjusted amount.

(6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke acceptance except as provided in this section. The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured employer must prove, by a preponderance of the evidence, that the claim is not compensable or that

the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are payable from the date any such benefits were terminated under the denial. Except as provided in ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer a copy of the notice of acceptance.

(b) The notice of acceptance shall:

(A) Specify what conditions are compensable.

(B) Advise the claimant whether the claim is considered disabling or nondisabling.

(C) Inform the claimant of the Expedited Claim Service and of the hearing and aggravation rights concerning nondisabling injuries, including the right to object to a decision that the injury of the claimant is nondisabling by requesting reclassification pursuant to ORS 656.277.

(D) Inform the claimant of employment reinstatement rights and responsibilities under ORS chapter 659A.

(E) Inform the claimant of assistance available to employers and workers from the Reemployment Assistance Program under ORS 656.622.

(F) Be modified by the insurer or self-insured employer from time to time as medical or other information changes a previously issued notice of acceptance.

(c) An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005 (7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition.

(d) An injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The insurer or self-insured employer has 60 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. A worker who fails to comply with the communication requirements of this paragraph or ORS 656.267 may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

(7)(a) After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical or omitted condition claims properly initiated pursuant to ORS 656.267 shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the insurer or self-insured employer receives written notice of such claims. A worker who fails to comply with the communication requirements of subsection (6) of this section or ORS 656.267 may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer.

(b) Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed.

(c) When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. The procedures specified in subsection (6)(d) of this section apply to this notice. Any objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition.

(8) The assigned claims agent in processing claims under ORS 656.054 shall send notice of acceptance or denial to the noncomplying employer.

(9) If an insurer or any other duly authorized agent of the employer for such purpose, on record with the Director of the Department of Consumer and Business Services denies a claim for compensation, written notice of such denial, stating the reason for the denial, and informing the worker of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the claimant. The insurer shall issue a copy of the notice of denial to the employer. The insurer shall notify the director of the denial in the manner the director prescribes by rule. The worker may request a hearing pursuant to ORS 656.319.

(10) Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a notice of closure, reconsideration order or litigation order, or the failure to appeal or seek review of such an order or notice of closure, shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted.

(11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees assessed under this section. The fees assessed by the director, an Administrative Law Judge, the board or the court under this section shall be reasonable attorney fees. In assessing fees, the director, an Administrative Law Judge, the board or the court shall consider the proportionate benefit to the injured worker. The board shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed $4,000 absent a showing of extraordinary circumstances. The maximum attorney fee awarded under this paragraph shall be adjusted annually on July 1 by the same percentage increase as made to the average weekly wage defined in ORS 656.211, if any. Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount and attorney fees described in this subsection. The action of the director and the review of the action taken by the director shall be subject to review under ORS 656.704.

(b) When the director does not have exclusive jurisdiction over proceedings regarding the assessment and payment of the additional amount and attorney fees described in this subsection, the provisions of this subsection shall apply in the other proceeding.

(12)(a) If payment is due on a disputed claim settlement authorized by ORS 656.289 and the insurer or self-insured employer has failed to make the payment in accordance with the requirements specified in the disputed claim settlement, the claimant or the claimant's attorney shall clearly notify the insurer or self-insured employer in writing that the payment is past due. If the required payment is not made within five business days after receipt of the notice by the insurer or self-insured employer, the director may assess a penalty and attorney fee in accordance with a matrix adopted by the director by rule.

(b) The director shall adopt by rule a matrix for the assessment of the penalties and attorney fees authorized under this subsection. The matrix shall provide for penalties based on a percentage of the settlement proceeds allocated to the claimant and for attorney fees based on a percentage of the settlement proceeds allocated to the claimant's attorney as an attorney fee.

(13) The insurer may authorize an employer to pay compensation to injured workers and shall reimburse employers for compensation so paid.

(14)(a) Injured workers have the duty to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers shall submit to and shall fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. Injured workers who are represented by an attorney shall have the right to have the attorney present during any personal or telephonic interview or deposition. If the injured worker is represented by an attorney, the insurer or self-insured employer shall pay the attorney a

reasonable attorney fee based upon an hourly rate for actual time spent during the personal or telephonic interview or deposition. After consultation with the Board of Governors of the Oregon State Bar, the Workers' Compensation Board shall adopt rules for the establishment, assessment and enforcement of an hourly attorney fee rate specified in this subsection.

(b) If the attorney is not willing or available to participate in an interview at a time reasonably chosen by the insurer or self-insured employer within 14 days of the request for interview and the insurer or self-insured employer has cause to believe that the attorney's unwillingness or unavailability is unreasonable and is preventing the worker from complying within 14 days of the request for interview, the insurer or self-insured employer shall notify the director. If the director determines that the attorney's unwillingness or unavailability is unreasonable, the director shall assess a civil penalty against the attorney of not more than $1,000.

(15) If the director finds that a worker fails to reasonably cooperate with an investigation involving an initial claim to establish a compensable injury or an aggravation claim to reopen the claim for a worsened condition, the director shall suspend all or part of the payment of compensation after notice to the worker. If the worker does not cooperate for an additional 30 days after the notice, the insurer or self-insured employer may deny the claim because of the worker's failure to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim within 60 days is suspended during the time of the worker's noncooperation. After such a denial, the worker shall not be granted a hearing or other proceeding under this chapter on the merits of the claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291 that the worker fully and completely cooperated with the investigation, that the worker failed to cooperate for reasons beyond the worker's control or that the investigative demands were unreasonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Administrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investigative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order the reinstatement of interim compensation if appropriate and remand the claim to the insurer or self-insured employer to accept or deny the claim.

(16) In accordance with ORS 656.283 (3), the Administrative Law Judge assigned a request for hearing for a claim for compensation involving more than one potentially responsible employer or insurer may specify what is required of an injured worker to reasonably cooperate with the investigation of the claim as required by subsection (14) of this section.

SECTION 3. (1) The amendments to ORS 656.262 by sections 1 and 2 of this 2022 Act apply to all claims that exist on, or arise on or after, January 1, 2024, regardless of the date of injury or the date on which the claim is filed.

(2) Notwithstanding subsection (1) of this section, the amendments to ORS 656.262 by sections 1 and 2 of this 2022 Act do not apply to disputes in which a final determination is made prior to January 1, 2024.

SECTION 4. ORS 656.268 is amended to read:

656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. The insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the Department of Consumer and Business Services, and determine the extent of the worker's permanent disability, provided the worker is not enrolled and actively engaged in training according to rules adopted by the director pursuant to ORS 656.340 and 656.726, when **one of the following conditions is met**:

(a) The worker has become medically stationary and there is sufficient information to determine permanent disability[*;*]**. Notwithstanding any other provision of this chapter, a physician or nurse practitioner may not retroactively determine a worker to be medically stationary more than 60 days prior to the date of the determination except in the case of claims that are subject to subsection (13) of this section. An insurer or self-insured employer must mail or**

deliver written notice to a worker and to the worker's attorney, if the worker is represented, within seven days following receipt of information that the worker is medically stationary.

(b) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions, and there is sufficient information to determine permanent disability, the likely permanent disability that would have been due to the current accepted condition shall be estimated**.**[*;*]

(c) Without the approval of the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245, the worker fails to seek medical treatment for a period of 30 days or the worker fails to attend a closing examination, unless the worker affirmatively establishes that such failure is attributable to reasons beyond the worker's control**.**[*; or*]

(d) An insurer or self-insured employer finds that a worker who has been receiving permanent total disability benefits has materially improved and is capable of regularly performing work at a gainful and suitable occupation.

(2) If the worker is enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately reduced by any sums earned during the training.

(3) A copy of all medical reports and reports of vocational rehabilitation agencies or counselors shall be furnished to the worker, if requested by the worker.

(4) Temporary total disability benefits shall continue until whichever of the following events first occurs:

(a) The worker returns to regular or modified employment;

(b) The attending physician or nurse practitioner who has authorized temporary disability benefits for the worker under ORS 656.245 advises the worker and documents in writing that the worker is released to return to regular employment;

(c) The attending physician or nurse practitioner who has authorized temporary disability benefits for the worker under ORS 656.245 advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment. However, an offer of modified employment may be refused by the worker without the termination of temporary total disability benefits if the offer:

(A) Requires a commute that is beyond the physical capacity of the worker according to the worker's attending physician or the nurse practitioner who may authorize temporary disability under ORS 656.245;

(B) Is at a work site more than 50 miles one way from where the worker was injured unless the site is less than 50 miles from the worker's residence or the intent of the parties at the time of hire or as established by the pattern of employment prior to the injury was that the employer had multiple or mobile work sites and the worker could be assigned to any such site;

(C) Is not with the employer at injury;

(D) Is not at a work site of the employer at injury;

(E) Is not consistent with the existing written shift change policy or is not consistent with common practice of the employer at injury or aggravation; or

(F) Is not consistent with an existing shift change provision of an applicable collective bargaining agreement;

(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262 (4) or other provisions of this chapter; or

(e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection, the attending physician or nurse practitioner who has authorized temporary disability benefits under ORS 656.245 for a home care worker or a personal support worker who has been made a subject worker pursuant to ORS 656.039 advises the home care worker or personal support worker and documents in writing that the home care worker or personal support worker is released to return to modified employment,

appropriate modified employment is offered in writing by the Home Care Commission or a designee of the commission to the home care worker or personal support worker for any client of the Department of Human Services who employs a home care worker or personal support worker and the worker fails to begin the employment.

(5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker's disability in closure of the claim shall be pursuant to the standards prescribed by the director.

(b) The insurer or self-insured employer shall issue a notice of closure of the claim to the worker, to the worker's attorney if the worker is represented, and to the director. If the worker is deceased at the time the notice of closure is issued, the insurer or self-insured employer shall mail the worker's copy of the notice of closure, addressed to the estate of the worker, to the worker's last known address and may mail copies of the notice of closure to any known or potential beneficiaries to the estate of the deceased worker.

(c) The notice of closure must inform:

(A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissatisfied with the terms of the notice of closure;

(B) The worker of:

(i) The amount of any further compensation, including permanent disability compensation to be awarded;

(ii) The duration of temporary total or temporary partial disability compensation;

(iii) The right of the worker or beneficiaries of the worker who were mailed a copy of the notice of closure under paragraph (b) of this subsection to request reconsideration by the director under this section within 60 days of the date of the notice of closure;

(iv) The right of beneficiaries who were not mailed a copy of the notice of closure under paragraph (b) of this subsection to request reconsideration by the director under this section within one year of the date the notice of closure was mailed to the estate of the worker under paragraph (b) of this subsection;

(v) The right of the insurer or self-insured employer to request reconsideration by the director under this section within seven days of the date of the notice of closure;

(vi) The aggravation rights; and

(vii) Any other information as the director may require; and

(C) Any beneficiaries of death benefits to which they may be entitled pursuant to ORS 656.204 and 656.208.

(d) If the insurer or self-insured employer has not issued a notice of closure, the worker may request closure. Within 10 days of receipt of a written request from the worker, the insurer or self-insured employer shall issue a notice of closure if the requirements of this section have been met or a notice of refusal to close if the requirements of this section have not been met. A notice of refusal to close shall advise the worker of:

(A) The decision not to close;

(B) The right of the worker to request a hearing pursuant to ORS 656.283 within 60 days of the date of the notice of refusal to close;

(C) The right to be represented by an attorney; and

(D) Any other information as the director may require.

(e) If a worker, a worker's beneficiary, an insurer or a self-insured employer objects to the notice of closure, the objecting party first must request reconsideration by the director under this section. A worker's request for reconsideration must be made within 60 days of the date of the notice of closure. If the worker is deceased at the time the notice of closure is issued, a request for reconsideration by a beneficiary of the worker who was mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within 60 days of the date of the notice of closure. A request for reconsideration by a beneficiary to the estate of a deceased worker who was not mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within one year of the date the notice of closure was mailed to the estate of the worker under paragraph (b) of this subsection. A request for reconsideration by an insurer or self-insured employer may be

based only on disagreement with the findings used to rate impairment and must be made within seven days of the date of the notice of closure.

(f) If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing on the claim and if a finding is made at the hearing that the notice of closure or refusal to close was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant.

(g) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant. If the increase in compensation results from information that the insurer or self-insured employer demonstrates the insurer or self-insured employer could not reasonably have known at the time of claim closure, from new information obtained through a medical arbiter examination or from a determination order issued by the director that addresses the extent of the worker's permanent disability that is not based on the standards adopted pursuant to ORS 656.726 (4)(f), the penalty shall not be assessed.

(6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be held on each notice of closure. At the reconsideration proceeding:

(A) A deposition arranged by the worker, limited to the testimony and cross-examination of the worker about the worker's condition at the time of claim closure, shall become part of the reconsideration record. The deposition must be conducted subject to the opportunity for cross-examination by the insurer or self-insured employer and in accordance with rules adopted by the director. The cost of the court reporter, interpreter services, if necessary, and one original of the transcript of the deposition for the Department of Consumer and Business Services and one copy of the transcript of the deposition for each party shall be paid by the insurer or self-insured employer. The reconsideration proceeding may not be postponed to receive a deposition taken under this subparagraph. A deposition taken in accordance with this subparagraph may be received as evidence at a hearing even if the deposition is not prepared in time for use in the reconsideration proceeding.

(B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 at the time of claim closure.

(C) If the director determines that a claim was not closed in accordance with subsection (1) of this section, the director may rescind the closure.

(b) If necessary, the director may require additional medical or other information with respect to the claims and may postpone the reconsideration for not more than 60 additional calendar days.

(c) In any reconsideration proceeding under this section in which the worker was represented by an attorney, the director shall order the insurer or self-insured employer to pay to the attorney, out of the additional compensation awarded, an amount equal to 10 percent of any additional compensation awarded to the worker.

(d) Except as provided in subsection (7) of this section, the reconsideration proceeding shall be completed within 18 working days from the date the reconsideration proceeding begins, and shall be performed by a special evaluation appellate unit within the department. The deadline of 18 working days may be postponed by an additional 60 calendar days if within the 18 working days the department mails notice of review by a medical arbiter. If an order on reconsideration has not been mailed on or before 18 working days from the date the reconsideration proceeding begins, or within 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this subsection, or within such additional time as provided in subsection (8) of this section when reconsid-

eration is postponed further because the worker has failed to cooperate in the medical arbiter examination, reconsideration shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure was mailed on the date the order was due to issue.

(e) The period for completing the reconsideration proceeding described in paragraph (d) of this subsection begins upon receipt by the director of a worker's or a beneficiary's request for reconsideration pursuant to subsection (5)(e) of this section. If the insurer or self-insured employer requests reconsideration, the period for reconsideration begins upon the earlier of the date of the request for reconsideration by the worker or beneficiary, the date of receipt of a waiver from the worker or beneficiary of the right to request reconsideration or the date of expiration of the right of the worker or beneficiary to request reconsideration. If a party elects not to file a separate request for reconsideration, the party does not waive the right to fully participate in the reconsideration proceeding, including the right to proceed with the reconsideration if the initiating party withdraws the request for reconsideration.

(f) Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding.

(g) If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 30 days from the date of the reconsideration order.

(7)(a) The director may delay the reconsideration proceeding and toll the reconsideration timeline established under subsection (6) of this section for up to 45 calendar days if:

(A) A request for reconsideration of a notice of closure has been made to the director within 60 days of the date of the notice of closure;

(B) The parties are actively engaged in settlement negotiations that include issues in dispute at reconsideration;

(C) The parties agree to the delay; and

(D) Both parties notify the director before the 18th working day after the reconsideration proceeding has begun that they request a delay under this subsection.

(b) A delay of the reconsideration proceeding granted by the director under this subsection expires:

(A) If a party requests the director to resume the reconsideration proceeding before the expiration of the delay period;

(B) If the parties reach a settlement and the director receives a copy of the approved settlement documents before the expiration of the delay period; or

(C) On the next calendar day following the expiration of the delay period authorized by the director.

(c) Upon expiration of a delay granted under this subsection, the timeline for the completion of the reconsideration proceeding shall resume as if the delay had never been granted.

(d) Compensation due the worker shall continue to be paid during the period of delay authorized under this subsection.

(e) The director may authorize only one delay period for each reconsideration proceeding.

(8)(a) If the basis for objection to a notice of closure issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director.

(b) If the director determines that insufficient medical information is available to determine disability, the director may appoint, and refer the claim to, a medical arbiter.

(c) At the request of either of the parties, the director shall appoint a panel of as many as three medical arbiters in accordance with criteria that the director sets by rule.

(d) The arbiter, or panel of medical arbiters, must be chosen from among a list of physicians qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) whom the director selected in consultation with the Oregon Medical Board and the committee referred to in ORS 656.790.

(e)(A) The medical arbiter or panel of medical arbiters may examine the worker and perform such tests as may be reasonable and necessary to establish the worker's impairment.

(B) If the director determines that the worker failed to attend the examination without good cause or failed to cooperate with the medical arbiter, or panel of medical arbiters, the director shall postpone the reconsideration proceedings for up to 60 days from the date of the determination that the worker failed to attend or cooperate, and shall suspend all disability benefits resulting from this or any prior opening of the claim until such time as the worker attends and cooperates with the examination or the request for reconsideration is withdrawn. Any additional evidence regarding good cause must be submitted prior to the conclusion of the 60-day postponement period.

(C) At the conclusion of the 60-day postponement period, if the worker has not attended and cooperated with a medical arbiter examination or established good cause, the worker may not attend a medical arbiter examination for this claim closure. The reconsideration record must be closed, and the director shall issue an order on reconsideration based upon the existing record.

(D) All disability benefits suspended under this subsection, including all disability benefits awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers' Compensation Board or upon court review, are not due and payable to the worker.

(f) The insurer or self-insured employer shall pay the costs of examination and review by the medical arbiter or panel of medical arbiters.

(g) The findings of the medical arbiter or panel of medical arbiters must be submitted to the director for reconsideration of the notice of closure.

(h) After reconsideration, no subsequent medical evidence of the worker's impairment is admissible before the director, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure.

(i)(A) If the basis for objection to a notice of closure issued under this section is a disagreement with the impairment used in rating the worker's disability, and the director determines that the worker is not medically stationary at the time of the reconsideration or that the closure was not made pursuant to this section, the director is not required to appoint a medical arbiter before completing the reconsideration proceeding.

(B) If the worker's condition has substantially changed since the notice of closure, upon the consent of all the parties to the claim, the director shall postpone the proceeding until the worker's condition is appropriate for claim closure under subsection (1) of this section.

(9) No hearing shall be held on any issue that was not raised and preserved before the director at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing.

(10) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due for work disability under the closure shall be suspended, and the worker shall receive temporary disability compensation and any permanent disability payments due for impairment while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured employer shall again close the claim pursuant to this section if the worker is medically stationary or if the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the duration of temporary total or temporary partial disability compensation. Permanent disability compensation shall be redetermined for work disability only. If the worker has returned to work or the worker's attending physician has released the worker to return to regular or modified employment, the insurer or self-insured employer shall again close the claim. This notice of closure may be appealed only in the same manner as are other notices of closure under this section.

(11) If the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 has approved the worker's return to work and there is a labor dispute in progress at the place of employment, the worker may refuse to return to that employment without loss of reemployment rights or any vocational assistance provided by this chapter.

(12) Any notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the notice of closure, including disallowance of permanent disa-

bility payments prematurely made, crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid.

(13) An insurer or self-insured employer may take a credit or offset of previously paid workers' compensation benefits or payments against any further workers' compensation benefits or payments due a worker from that insurer or self-insured employer when the worker admits to having obtained the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction is entered against the worker for having obtained the previously paid benefits through fraud. Benefits or payments obtained through fraud by a worker may not be included in any data used for ratemaking or individual employer rating or dividend calculations by an insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the director.

(14)(a) An insurer or self-insured employer may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer. When overpayments are recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment shall not exceed 25 percent of the payment, without prior authorization from the worker.

(b) An insurer or self-insured employer may suspend and offset any compensation payable to the beneficiary of the worker, and recover an overpayment of permanent total disability benefits caused by the failure of the worker's beneficiaries to notify the insurer or self-insured employer about the death of the worker.

(15) Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied.

(16)(a) Except as provided under subsection (13) of this section, an insurer or self-insured employer may not recover an overpayment from a worker's permanent partial disability compensation for overpayments, offsets or credits of wage loss in an amount that exceeds 50 percent of the total compensation awarded to the worker.

(b) An insurer or self-insured employer may not declare an overpayment of any compensation that was paid more than two years prior to the date of the declaration.

SECTION 5. ORS 656.268, as amended by section 2, chapter 47, Oregon Laws 2021, is amended to read:

656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. The insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the Department of Consumer and Business Services, and determine the extent of the worker's permanent disability, provided the worker is not enrolled and actively engaged in training according to rules adopted by the director pursuant to ORS 656.340 and 656.726, when **one of the following conditions is met**:

(a) The worker has become medically stationary and there is sufficient information to determine permanent disability[*;*]**. Notwithstanding any other provision of this chapter, a physician or nurse practitioner may not retroactively determine a worker to be medically stationary more than 60 days prior to the date of the determination except in the case of claims that are subject to subsection (13) of this section. An insurer or self-insured employer must mail or deliver written notice to a worker and to the worker's attorney, if the worker is represented, within seven days following receipt of information that the worker is medically stationary.**

(b) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions, and there is sufficient information to determine permanent disability, the likely permanent disability that would have been due to the current accepted condition shall be estimated**.**[*;*]

(c) Without the approval of the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245, the worker fails to seek medical treatment for a period of 30 days or the worker fails to attend a closing examination, unless the worker affirmatively establishes that such failure is attributable to reasons beyond the worker's control.[*; or*]

(d) An insurer or self-insured employer finds that a worker who has been receiving permanent total disability benefits has materially improved and is capable of regularly performing work at a gainful and suitable occupation.

(2) If the worker is enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately reduced by any sums earned during the training.

(3) A copy of all medical reports and reports of vocational rehabilitation agencies or counselors shall be furnished to the worker, if requested by the worker.

(4) Temporary total disability benefits shall continue until whichever of the following events first occurs:

(a) The worker returns to regular or modified employment;

(b) The attending physician or nurse practitioner who has authorized temporary disability benefits for the worker under ORS 656.245 advises the worker and documents in writing that the worker is released to return to regular employment;

(c) The attending physician or nurse practitioner who has authorized temporary disability benefits for the worker under ORS 656.245 advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment. However, an offer of modified employment may be refused by the worker without the termination of temporary total disability benefits if the offer:

(A) Requires a commute that is beyond the physical capacity of the worker according to the worker's attending physician or the nurse practitioner who may authorize temporary disability under ORS 656.245;

(B) Is at a work site more than 50 miles one way from where the worker was injured unless the site is less than 50 miles from the worker's residence or the intent of the parties at the time of hire or as established by the pattern of employment prior to the injury was that the employer had multiple or mobile work sites and the worker could be assigned to any such site;

(C) Is not with the employer at injury;

(D) Is not at a work site of the employer at injury;

(E) Is not consistent with the existing written shift change policy or is not consistent with common practice of the employer at injury or aggravation; or

(F) Is not consistent with an existing shift change provision of an applicable collective bargaining agreement;

(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262 (4) or other provisions of this chapter; or

(e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection, the attending physician or nurse practitioner who has authorized temporary disability benefits under ORS 656.245 for a home care worker or a personal support worker who has been made a subject worker pursuant to ORS 656.039 advises the home care worker or personal support worker and documents in writing that the home care worker or personal support worker is released to return to modified employment, appropriate modified employment is offered in writing by the Home Care Commission or a designee of the commission to the home care worker or personal support worker for any client of the Department of Human Services who employs a home care worker or personal support worker and the worker fails to begin the employment.

(5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker's disability in closure of the claim shall be pursuant to the standards prescribed by the director.

(b) The insurer or self-insured employer shall issue a notice of closure of the claim to the worker and to the worker's attorney if the worker is represented. The insurer or self-insured employer shall

notify the director of the closure in the manner the director prescribes by rule. If the worker is deceased at the time the notice of closure is issued, the insurer or self-insured employer shall mail the worker's copy of the notice of closure, addressed to the estate of the worker, to the worker's last known address and may mail copies of the notice of closure to any known or potential beneficiaries to the estate of the deceased worker.

(c) The notice of closure must inform:

(A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissatisfied with the terms of the notice of closure;

(B) The worker of:

(i) The amount of any further compensation, including permanent disability compensation to be awarded;

(ii) The duration of temporary total or temporary partial disability compensation;

(iii) The right of the worker or beneficiaries of the worker who were mailed a copy of the notice of closure under paragraph (b) of this subsection to request reconsideration by the director under this section within 60 days of the date of the notice of closure;

(iv) The right of beneficiaries who were not mailed a copy of the notice of closure under paragraph (b) of this subsection to request reconsideration by the director under this section within one year of the date the notice of closure was mailed to the estate of the worker under paragraph (b) of this subsection;

(v) The right of the insurer or self-insured employer to request reconsideration by the director under this section within seven days of the date of the notice of closure;

(vi) The aggravation rights; and

(vii) Any other information as the director may require; and

(C) Any beneficiaries of death benefits to which they may be entitled pursuant to ORS 656.204 and 656.208.

(d) If the insurer or self-insured employer has not issued a notice of closure, the worker may request closure. Within 10 days of receipt of a written request from the worker, the insurer or self-insured employer shall issue a notice of closure if the requirements of this section have been met or a notice of refusal to close if the requirements of this section have not been met. A notice of refusal to close shall advise the worker of:

(A) The decision not to close;

(B) The right of the worker to request a hearing pursuant to ORS 656.283 within 60 days of the date of the notice of refusal to close;

(C) The right to be represented by an attorney; and

(D) Any other information as the director may require.

(e) If a worker, a worker's beneficiary, an insurer or a self-insured employer objects to the notice of closure, the objecting party first must request reconsideration by the director under this section. A worker's request for reconsideration must be made within 60 days of the date of the notice of closure. If the worker is deceased at the time the notice of closure is issued, a request for reconsideration by a beneficiary of the worker who was mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within 60 days of the date of the notice of closure. A request for reconsideration by a beneficiary to the estate of a deceased worker who was not mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within one year of the date the notice of closure was mailed to the estate of the worker under paragraph (b) of this subsection. A request for reconsideration by an insurer or self-insured employer may be based only on disagreement with the findings used to rate impairment and must be made within seven days of the date of the notice of closure.

(f) If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing on the claim and if a finding is made at the hearing that the notice of closure or refusal to close was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid

to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant.

(g) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant. If the increase in compensation results from information that the insurer or self-insured employer demonstrates the insurer or self-insured employer could not reasonably have known at the time of claim closure, from new information obtained through a medical arbiter examination or from a determination order issued by the director that addresses the extent of the worker's permanent disability that is not based on the standards adopted pursuant to ORS 656.726 (4)(f), the penalty shall not be assessed.

(6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be held on each notice of closure. At the reconsideration proceeding:

(A) A deposition arranged by the worker, limited to the testimony and cross-examination of the worker about the worker's condition at the time of claim closure, shall become part of the reconsideration record. The deposition must be conducted subject to the opportunity for cross-examination by the insurer or self-insured employer and in accordance with rules adopted by the director. The cost of the court reporter, interpreter services, if necessary, and one original of the transcript of the deposition for the Department of Consumer and Business Services and one copy of the transcript of the deposition for each party shall be paid by the insurer or self-insured employer. The reconsideration proceeding may not be postponed to receive a deposition taken under this subparagraph. A deposition taken in accordance with this subparagraph may be received as evidence at a hearing even if the deposition is not prepared in time for use in the reconsideration proceeding.

(B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 at the time of claim closure.

(C) If the director determines that a claim was not closed in accordance with subsection (1) of this section, the director may rescind the closure.

(b) If necessary, the director may require additional medical or other information with respect to the claims and may postpone the reconsideration for not more than 60 additional calendar days.

(c) In any reconsideration proceeding under this section in which the worker was represented by an attorney, the director shall order the insurer or self-insured employer to pay to the attorney, out of the additional compensation awarded, an amount equal to 10 percent of any additional compensation awarded to the worker.

(d) Except as provided in subsection (7) of this section, the reconsideration proceeding shall be completed within 18 working days from the date the reconsideration proceeding begins, and shall be performed by a special evaluation appellate unit within the department. The deadline of 18 working days may be postponed by an additional 60 calendar days if within the 18 working days the department mails notice of review by a medical arbiter. If an order on reconsideration has not been mailed on or before 18 working days from the date the reconsideration proceeding begins, or within 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this subsection, or within such additional time as provided in subsection (8) of this section when reconsideration is postponed further because the worker has failed to cooperate in the medical arbiter examination, reconsideration shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure was mailed on the date the order was due to issue.

(e) The period for completing the reconsideration proceeding described in paragraph (d) of this subsection begins upon receipt by the director of a worker's or a beneficiary's request for recon-

sideration pursuant to subsection (5)(e) of this section. If the insurer or self-insured employer requests reconsideration, the period for reconsideration begins upon the earlier of the date of the request for reconsideration by the worker or beneficiary, the date of receipt of a waiver from the worker or beneficiary of the right to request reconsideration or the date of expiration of the right of the worker or beneficiary to request reconsideration. If a party elects not to file a separate request for reconsideration, the party does not waive the right to fully participate in the reconsideration proceeding, including the right to proceed with the reconsideration if the initiating party withdraws the request for reconsideration.

(f) Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding.

(g) If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 30 days from the date of the reconsideration order.

(7)(a) The director may delay the reconsideration proceeding and toll the reconsideration timeline established under subsection (6) of this section for up to 45 calendar days if:

(A) A request for reconsideration of a notice of closure has been made to the director within 60 days of the date of the notice of closure;

(B) The parties are actively engaged in settlement negotiations that include issues in dispute at reconsideration;

(C) The parties agree to the delay; and

(D) Both parties notify the director before the 18th working day after the reconsideration proceeding has begun that they request a delay under this subsection.

(b) A delay of the reconsideration proceeding granted by the director under this subsection expires:

(A) If a party requests the director to resume the reconsideration proceeding before the expiration of the delay period;

(B) If the parties reach a settlement and the director receives a copy of the approved settlement documents before the expiration of the delay period; or

(C) On the next calendar day following the expiration of the delay period authorized by the director.

(c) Upon expiration of a delay granted under this subsection, the timeline for the completion of the reconsideration proceeding shall resume as if the delay had never been granted.

(d) Compensation due the worker shall continue to be paid during the period of delay authorized under this subsection.

(e) The director may authorize only one delay period for each reconsideration proceeding.

(8)(a) If the basis for objection to a notice of closure issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director.

(b) If the director determines that insufficient medical information is available to determine disability, the director may appoint, and refer the claim to, a medical arbiter.

(c) At the request of either of the parties, the director shall appoint a panel of as many as three medical arbiters in accordance with criteria that the director sets by rule.

(d) The arbiter, or panel of medical arbiters, must be chosen from among a list of physicians qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) whom the director selected in consultation with the Oregon Medical Board and the committee referred to in ORS 656.790.

(e)(A) The medical arbiter or panel of medical arbiters may examine the worker and perform such tests as may be reasonable and necessary to establish the worker's impairment.

(B) If the director determines that the worker failed to attend the examination without good cause or failed to cooperate with the medical arbiter, or panel of medical arbiters, the director shall postpone the reconsideration proceedings for up to 60 days from the date of the determination that the worker failed to attend or cooperate, and shall suspend all disability benefits resulting from this or any prior opening of the claim until such time as the worker attends and cooperates with the

examination or the request for reconsideration is withdrawn. Any additional evidence regarding good cause must be submitted prior to the conclusion of the 60-day postponement period.

(C) At the conclusion of the 60-day postponement period, if the worker has not attended and cooperated with a medical arbiter examination or established good cause, the worker may not attend a medical arbiter examination for this claim closure. The reconsideration record must be closed, and the director shall issue an order on reconsideration based upon the existing record.

(D) All disability benefits suspended under this subsection, including all disability benefits awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers' Compensation Board or upon court review, are not due and payable to the worker.

(f) The insurer or self-insured employer shall pay the costs of examination and review by the medical arbiter or panel of medical arbiters.

(g) The findings of the medical arbiter or panel of medical arbiters must be submitted to the director for reconsideration of the notice of closure.

(h) After reconsideration, no subsequent medical evidence of the worker's impairment is admissible before the director, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure.

(i)(A) If the basis for objection to a notice of closure issued under this section is a disagreement with the impairment used in rating the worker's disability, and the director determines that the worker is not medically stationary at the time of the reconsideration or that the closure was not made pursuant to this section, the director is not required to appoint a medical arbiter before completing the reconsideration proceeding.

(B) If the worker's condition has substantially changed since the notice of closure, upon the consent of all the parties to the claim, the director shall postpone the proceeding until the worker's condition is appropriate for claim closure under subsection (1) of this section.

(9) No hearing shall be held on any issue that was not raised and preserved before the director at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing.

(10) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due for work disability under the closure shall be suspended, and the worker shall receive temporary disability compensation and any permanent disability payments due for impairment while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured employer shall again close the claim pursuant to this section if the worker is medically stationary or if the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the duration of temporary total or temporary partial disability compensation. Permanent disability compensation shall be redetermined for work disability only. If the worker has returned to work or the worker's attending physician has released the worker to return to regular or modified employment, the insurer or self-insured employer shall again close the claim. This notice of closure may be appealed only in the same manner as are other notices of closure under this section.

(11) If the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 has approved the worker's return to work and there is a labor dispute in progress at the place of employment, the worker may refuse to return to that employment without loss of reemployment rights or any vocational assistance provided by this chapter.

(12) Any notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid.

(13) An insurer or self-insured employer may take a credit or offset of previously paid workers' compensation benefits or payments against any further workers' compensation benefits or payments

due a worker from that insurer or self-insured employer when the worker admits to having obtained the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction is entered against the worker for having obtained the previously paid benefits through fraud. Benefits or payments obtained through fraud by a worker may not be included in any data used for ratemaking or individual employer rating or dividend calculations by an insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the director.

(14)(a) An insurer or self-insured employer may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer. When overpayments are recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment shall not exceed 25 percent of the payment, without prior authorization from the worker.

(b) An insurer or self-insured employer may suspend and offset any compensation payable to the beneficiary of the worker, and recover an overpayment of permanent total disability benefits caused by the failure of the worker's beneficiaries to notify the insurer or self-insured employer about the death of the worker.

(15) Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied.

(16)(a) Except as provided under subsection (13) of this section, an insurer or self-insured employer may not recover an overpayment from a worker's permanent partial disability compensation for overpayments, offsets or credits of wage loss in an amount that exceeds 50 percent of the total compensation awarded to the worker.

(b) An insurer or self-insured employer may not declare an overpayment of any compensation that was paid more than two years prior to the date of the declaration.

SECTION 6. (1) The amendments to ORS 656.268 by sections 4 and 5 of this 2022 Act apply to all claims that exist on, or arise on or after, January 1, 2024, regardless of the date of injury or the date on which the claim is filed.

(2) Notwithstanding subsection (1) of this section, the amendments to ORS 656.268 by sections 4 and 5 of this 2022 Act do not apply to disputes in which a final determination is made prior to January 1, 2024.

Passed by House February 23, 2022

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Dan Rayfield, Speaker of House

Passed by Senate March 3, 2022

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Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2022

Approved:

.....M.,....., 2022

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2022

.....
Shemia Fagan, Secretary of State

Oregon
Kate Brown, Governor

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Salem, OR 97309-0405
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Dec. 19, 2022

Notice of permanent changes to workers' compensation rules

Caption: Implementation of Enrolled House Bill 4138 (2022); Ombuds office name update

The Workers' Compensation Division has adopted permanent changes to:

- OAR 436-030, Claim Closure and Reconsideration;
- OAR 436-060, Claims Administration; and
- OAR 436-120, Vocational Assistance to Injured Workers.

These changes are effective Jan. 1, 2024.

Rulemaking notice was published in the November, 2022 *Oregon Bulletin*.

Summary of changes to OAR 436-030, Claim Closure and Reconsideration:

- Rule 0015 is amended to:
  - Update the name of the Ombudsman for Injured Workers to the Ombuds Office for Oregon Workers when an "Updated Notice of Acceptance and Closure" is sent to the estate of a worker after an instant fatality;
  - Require that notice to the worker after the claim qualifies for closure must advise the worker that any temporary disability "currently being paid" will end soon, to distinguish this notice from the notice required under Enrolled HB 4138 (2022) that informs the worker the reason temporary disability is no longer due and payable; and
  - Include in the list of insurer responsibilities the requirement to mail or deliver the notice required under OAR 436-060-0015(8), which is notice of medically stationary status.
- Rule 0020 is amended to:
  - Update the name of the Ombudsman for Injured Workers to the Ombuds Office for Oregon Workers on the Notice of Closure; and
  - For claims closed after the end of an authorized training program, require a current (within 60 days before closure) determination of medically stationary status and residual functional capacity (relevant for work disability); the current rule allows three months.
- Rule 0035 is amended to:
  - Specify that a physician or nurse practitioner may not retroactively determine a worker to be medically stationary more than 60 days prior to the date of the determination, except in the case of claims that are subject to ORS 656.268(13); and
  - Provide that if the medically stationary date under section (1), (4), (5), or (6) of rule 0035 is more than 60 days prior to the date of the determination, the medically stationary date is the 60th day prior to the date of the determination.

Summary of changes to OAR 436-060, Claims Administration:

- Rule 0015 is amended to:

  - Replace a reference to "weekends and legal holidays," with "Saturday, Sunday, or legal holidays under ORS 187.010 and 187.020" (which are days excluded from the 48 hours allowed for response to worker inquiries);
  - Describe the new notice of end of temporary disability benefits required under Enrolled HB 4138 (2022); and
  - Describe the new notice of medically stationary status required under Enrolled HB 4138 (2022).
- Rule 0018 is amended to update the name of the Ombudsman for Injured Workers to the Ombuds Office for Oregon Workers for written notices regarding reclassification.
- Rule 0020 is amended to replace the requirement to send the worker an explanation for stopping temporary disability payments in place of a scheduled payment with direction that the insurer may not end temporary disability benefits until written notice has been mailed or delivered under OAR 436-060-0015(7) (regarding end of temporary disability).
- Rule 0095 is amended to:
  - Explain that the director may impose a monetary penalty against the worker under OAR 436-010-0265; and
  - Update the name of the Ombudsman for Injured Workers to the Ombuds Office for Oregon Workers for written notice regarding an independent medical exam.
- Rule 0137 is amended to update the name of the Ombudsman for Injured Workers to the Ombuds Office for Oregon Workers for written notice regarding a vocational evaluation.
- Rule 0147 is amended to update the name of the Ombudsman for Injured Workers to the Ombuds Office for Oregon Workers as a consultation resource for unrepresented workers who have questions about worker-requested medical exams.
- Rule 0170 is amended to update a citation to ORS 656.268, because a new subsection (16) was added by Enrolled House Bill 4138 (2022).

Summary of changes to OAR 436-120, Vocational Assistance to Injured Workers:

- Rule 0012 is amended to update the name of the Ombudsman for Injured Workers to the Ombuds Office for Oregon Workers for notices to workers about vocational assistance.
- Rule 0443 is amended to:
  - Require that the insurer may not end temporary disability benefits until written notice under OAR 436-060-0015(7) (regarding end of temporary disability) has been mailed or delivered to the worker and the worker's attorney, if the worker is represented; and
  - Update a citation to reflect renumbering within the rule.

Sally Coen	Sally Coen	Dec. 19, 2022
Authorized Signer	Printed name	Date

Final rules, with marked changes, have been posted to the Workers' Compensation Division's website: https://wcd.oregon.gov/laws/Pages/new-rules.aspx.

Mailing distribution: Agency email lists

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

Effective Jan. 1, 2024

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Historical rules: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

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OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 030

Revisions are marked: Added | ~~Deleted~~

436-030-0015 Insurer Responsibility

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

(a) Providing the director, the parties, and the worker's attorney if the worker is represented, a copy of the Notice of Closure, a copy of the Notice of Closure Worksheet (Form 2807) upon which the Notice is based, a completed Insurer Notice of Closure Summary (Form 1503), and an Updated Notice of Acceptance at Closure that specifies which conditions are compensable, as prescribed in OAR 436-030-0020;

(b) Maintaining a copy of the worksheet and records upon which the Notice of Closure is based in its claim file for audit purposes under OAR 436-050; and

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

(A) The Updated Notice of Acceptance at Closure must contain the following title, information, and language:

(i) Title: "Updated Notice of Acceptance at Closure";

(ii) Information: A list of all compensable conditions, even if a condition was denied, ordered accepted by litigation, and is under appeal. Any conditions under appeal and those which were the basis for this claim opening must be specifically identified; and

(iii) Language, in bold print:

"Notice to Worker: This notice restates and includes all prior acceptances. The conditions that were the basis of this claim opening were the only conditions considered at the time of claim closure. The insurer or self-insured employer is not required to pay any disability compensation for any condition specifically identified as under appeal, unless and until the condition is found to be compensable after all litigation is complete. Appeal of any denied conditions or objections to this notice will not delay claim closure. Any condition found compensable after the Notice of Closure is issued will require the insurer to reopen the claim for processing of that condition. If you believe a condition has been incorrectly omitted from this notice, or this notice is otherwise deficient, you must communicate the specific objection to the insurer in writing.";

(B) In the case of an instant fatality, the Updated Notice of Acceptance may be combined with the Notice of Closure if the following is included:

(i) Title: "Updated Notice of Acceptance and Closure";

(ii) Information: A statement that beneficiaries may be entitled to death benefits under ORS 656.204 and 656.208, and the medically stationary date; and

(iii) Language, in bold print:

"Notice to Worker's Beneficiary or Estate: This notice restates any prior acceptances. The insurer is required to determine the appropriate benefits to be paid to any beneficiaries and begin those payments within 30 days of the mailing date of this notice.

If you disagree with the notice of acceptance, you may appeal the decision to the Workers' Compensation Board, 2601 25th Street SE, Suite 150, Salem, OR 97302-1280 within 30 days of the mailing date.

A beneficiary who was mailed this notice may request reconsideration of the notice by the Workers' Compensation Division, Appellate Review Unit, 350 Winter Street NE, PO Box 14480 Salem, OR 97309-0405 within 60 days of the mailing date of this notice.

Beneficiaries who were not mailed a copy of this notice may request reconsideration of this notice within one year of the date this notice was mailed to the estate of the worker.

If you have questions about this notice, you may contact the Ombuds~~man for Injured~~ Office for Oregon Workers, the Workers' Compensation Division, or consult with an attorney."

(C) If the "Initial Notice of Acceptance" is issued at the same time as the "Updated Notice of Acceptance at Closure," both titles must appear near the top of the document.

(D) When an omission or error requires correcting an Updated Notice of Acceptance at Closure, the document must be clearly titled "Corrected Updated Notice of Acceptance at Closure."

(2) The insurer or self-insured employer is not required to pay any disability compensation for any condition under appeal and specifically identified as such, unless and until the condition is found to be compensable after all litigation is complete.

(3) Copies of Notices of Refusal to Close must be mailed to the director and the parties, and to the worker's attorney, if the worker is represented.

(4) In claims with a date of injury on or after January 1, 2005, where the worker has not returned to regular work and ORS 656.726(4)(f) does not apply, or in claims with a date of injury on or after January 1, 2006, when the worker has not been released to regular work and ORS 656.726(4)(f) does not apply, the insurer must consider:

(a) The worker's age at the time the notice is issued;

(b) Adaptability to return to employment;

(c) The worker's level of education; and

(d) The worker's work history, including an accurate description of the physical requirements of the worker's job held at the time of injury, for the period from five years before the date of injury to the mailing date of the Notice of Closure with dates or period of time spent at each position, tasks performed or level of specific vocational preparation (SVP), and physical requirements. If the insurer cannot obtain five years of work history despite all reasonable efforts, the insurer must document its efforts and provide as much work history as it can obtain.

(5) In claims where the date of injury is before January 1, 2005, the worker has not returned or been released to regular work, ORS 656.726(4)(f) does not apply, and the claim involves injury to, or disease of, unscheduled body parts, areas, or systems, the insurer must consider:

(a) The worker's age at time the notice is issued;

(b) Adaptability to return to employment:

(c) The worker's level of education; and

(d) The worker's work history, including an accurate description of the physical requirements of the worker's job held at the time of injury, for the period from five years before the date of injury to the mailing date of the Notice of Closure with dates or period of time spent at each position, tasks performed or level of specific vocational preparation (SVP), and physical requirements.

(6) The insurer must consider any other records or information pertinent to claim determination prior to issuing a Notice of Closure.

(7) The insurer must notify the worker and the worker's attorney, if the worker is represented, in writing, when the insurer receives information that the worker's claim qualifies for closure under these rules.

(a) The insurer must send the written notice within three working days from the date the insurer receives the information, unless the claim has already been closed.

(b) The notice must advise the worker of impending claim closure and that any temporary disability benefits currently being paid~~payments~~ will end soon.

(8) The insurer must, within 14 days of closing the claim, provide the worker's attorney the same documents relied upon for claim closure.

(9) The insurer may not issue a Notice of Closure on an accepted nondisabling claim. Notices of Closure issued by the insurer in violation of this rule are void and without legal effect. Medically stationary status in nondisabling claims may be documented by the attending physician's statement of medically stationary status.

(10) When a condition is accepted after a closure and the claim has been reopened under ORS 656.262, the insurer must issue a Notice of Closure, considering only the newly accepted condition.

(11) Denials issued under ORS 656.262(7)(b), must clearly identify the phrase "major contributing cause" in the text of the denial.

(12) When a claim is closed where a designation of paying agent order (ORS 656.307) has been issued and the responsibility issue is not final by operation of law, the insurer processing the claim at the time of closure must send copies of the closure notice to the worker, the worker's attorney if the worker is represented, the director, and all parties involved in the responsibility issue.

(13) Forms 1503, 1644, and 2807 are published with Bulletin 139.

(14) The insurer must mail or deliver the notice required under OAR 436-060-0015(8).

Statutory authority: ORS 656.268 (OL2022, ch. 73, sections 4 & 5), 656.726
Statutes implemented: ORS 656.262, 656.268 (OL2022, ch. 73, sections 4 & 5), 656.331, 656.726
Hist: Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
Amended 6/13/22 as Admin. Order 22-056, eff. 7/1/22
Amended 12/19/22 as Admin. Order 22-068, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0020 Requirements for Claim Closure

(1) Issuance of a Notice of Closure. Unless the worker is enrolled and actively engaged in an authorized training plan under OAR 436-120, the insurer must issue a Notice of Closure on an accepted disabling claim within 14 days when:

(a) Medical information establishes that there is sufficient information to determine the extent of permanent disability and indicates that the worker is medically stationary;

(b) The compensable injury is no longer the major contributing cause of the worker's combined or consequential condition(s), a major contributing cause denial has been issued, and there is sufficient information to determine the extent of permanent disability;

(c) The worker fails to seek medical treatment for 30 days for reasons within the worker's control and the requirements for claim closure under OAR 436-030-0034 have been met;

(d) The worker fails to attend a mandatory closing examination for reasons within the worker's control and the requirements for claim closure under OAR 436-030-0034 have been met; or

(e) A worker receiving permanent total disability benefits has materially improved and is capable of regularly performing work at a gainful and suitable occupation.

(2) Sufficient Information. For purposes of determining the extent of permanent disability, except as provided in section (14) of this rule for closure after training, "sufficient information" requires: a qualifying statement of no permanent disability under subsection (a) of this section or a qualifying closing report under subsection (b) of this section. Additional documentation is required under subsection (c) of this section unless there is clear and convincing evidence that an attending physician or authorized nurse practitioner has released the worker to the job held at the time of injury or that the worker has returned to the job held at the time of injury.

(a) Qualifying statements of no permanent disability. A statement indicating that there is no permanent disability is sufficient if it meets all of the following requirements:

(A) Qualified providers. An authorized nurse practitioner or attending physician must provide or concur with the statement.

(B) Support by the medical record. The statement must be supported by the medical record. If the medical record reveals otherwise, a closing examination and report specified under subsection (b) of this section are required.

(C) In initial injury claims. In an initial injury claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment due to an accepted condition or a direct medical sequela of an accepted condition; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted condition or a direct medical sequela of an accepted condition.

(D) In new or omitted condition claims. In a new or omitted condition claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(E) In aggravation claims. In an aggravation claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(F) In occupational disease claims. In an occupational disease claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(b) Qualifying closing reports. A closing medical examination and report are required if there is a reasonable expectation of permanent disability. A closing report is sufficient if it meets all of the following requirements:

(A) Qualified providers. A type A attending physician or a chiropractic physician serving as the attending physician must provide or concur with the closing report.

(B) Release to regular work. If the worker has no permanent work restriction and the provider identified in paragraph (A) of this rule has not already clearly established the following information, the closing report must include a statement indicating that:

(i) The worker has no permanent work restriction; or

(ii) The worker is released, without restriction, to the job held at the time of injury.

(C) In initial injury claims. In an initial injury claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment due to an accepted condition or a direct medical sequela of an accepted condition; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted condition or a direct medical sequela of an accepted condition.

(D) In new or omitted condition claims. In a new or omitted condition claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(E) In aggravation claims. In an aggravation claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(F) In occupational disease claims. In an occupational disease claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(c) Additional documentation. Unless there is clear and convincing evidence that an attending physician or authorized nurse practitioner has released the worker to the job held at the time of injury (for dates of injury on or after January 1, 2006) or that the worker has returned to the job held at the time of injury, all of the following is required:

(A) An accurate description of the physical requirements of the worker's job held at the time of injury, which has been provided by certified mail to the worker and the worker's attorney, if any, either before closing the claim or at the time the claim is closed, unless the record clearly establishes the physical requirements of the worker's job held at the time of injury;

(B) The worker's wage established consistent with OAR 436-060;

(C) The worker's date of birth;

(D) Except as provided in OAR 436-030-0015(4)(d), the worker's work history for the period beginning five years before the date of injury to the mailing date of the Notice of Closure, including tasks performed or level of SVP, and physical demands; and

(E) The worker's level of formal education.

(3) When determining disability and issuing the Notice of Closure, the insurer must apply all statutes and rules consistent with their provisions, particularly as they relate to major contributing cause denials, worker's failure to seek treatment, worker's failure to attend a mandatory examination, medically stationary status, temporary disability, permanent partial and total disability, and review of permanent partial and total disability.

(4) When issuing a Notice of Closure (Form 1644), the insurer must prepare and attach a Notice of Closure Worksheet (Form 2807), as described by bulletin of the director, and an Insurer Notice of Closure Summary (Form 1503).

(5) The Notice of Closure (Form 1644) is effective the date it is mailed to the worker and to the worker's attorney if the worker is represented, or to the worker's estate if the worker is deceased, regardless of the date on the Notice itself.

(6) The Notice of Closure (Form 1644) must be in the form and format prescribed by the director in these rules and include only the following:

(a) The worker's name, address, and claim identification information;

(b) The appropriate dollar value of any individual scheduled or unscheduled permanent disability based on the value per degree for injuries occurring before January 1, 2005 or, for injuries occurring on or after January 1, 2005, the appropriate dollar value of any "whole person" permanent disability, including impairment and work disability as determined appropriate under OAR 436-035;

(c) The body part(s) awarded disability, coded to the table of body part codes as prescribed by the director;

(d) The percentage of loss of the specific body part(s), including either the number of degrees that loss represents as appropriate for injuries occurring before January 1, 2005, or the percentage of the whole person the worker's loss represents as appropriate for injuries occurring on or after January 1, 2005;

(e) If there is no permanent disability award for this Notice of Closure, a statement to that effect;

(f) The duration of temporary total and temporary partial disability compensation;

(g) The date the Notice of Closure was mailed;

(h) The medically stationary date or the date the claim statutorily qualifies for closure under OAR 436-030-0035 or 436-030-0034;

(i) The date the worker's aggravation rights end;

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

(k) A statement that the worker has the right to consult with the Ombuds~~man for Injured~~ Office for Oregon Workers;

(l) For claims with dates of injury before January 1, 2005, the rate in dollars per degree at which permanent disability, if any, will be paid based on date of injury as identified in Bulletin 111;

(m) For claims with dates of injury on or after January 1, 2005, the state's average weekly wage applicable to the worker's date of injury;

(n) The worker's return to work status;

(o) A general statement that the insurer has the authority to recover an overpayment;

(p) A statement that the worker has the right to be represented by an attorney; and

(q) A statement that the worker has the right to request a vocational eligibility evaluation under ORS 656.340.

(7) The Notice of Closure (Form 1644) must be accompanied by the following:

(a) The brochure "Understanding Claim Closure and Your Rights";

(b) A copy of summary worksheet Form 2807 containing information and findings that result in the data appearing on the Notice of Closure;

(c) An accurate description of the physical requirements of the worker's job held at the time of injury unless it is not required under (2)(a) or (2)(c) of this rule or it was previously provided under (2)(c)(A) of this rule;

(d) The Updated Notice of Acceptance at Closure which clearly identifies all accepted conditions in the claim and specifies those which have been denied and are on appeal or which were the basis for this opening of the claim; and

(e) A cover letter that:

(A) Specifically explains why the claim has been closed (e.g., expiration of a period of suspension without the worker resolving the problems identified, an attending physician stating the worker is medically stationary, worker failure to treat without attending physician authorization or establishing good cause for not treating);

(B) Lists and describes enclosed documents; and

(C) Notifies the worker about the end of temporary disability benefits, if any, and the anticipated start of permanent disability benefits, if any.

(8) A copy of the Notice of Closure must be mailed to each of the following persons at the same time, with each copy clearly identifying the intended recipient:

(a) The worker;

(b) The employer;

(c) The director; and

(d) The worker's attorney, if the worker is represented.

(9) If the worker is deceased at the time the Notice of Closure is issued:

(a) The worker's copy of the notice must be addressed to the estate of the worker and mailed to the worker's last known address.

(b) Copies of the notice may be mailed to any known or potential beneficiaries to the worker's estate. If a copy of the notice is mailed to a beneficiary, it must be mailed by both regular mail and certified mail return receipt requested.

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

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

(12) Insurers may allow adjustments of benefits awarded to the worker under the documentation requirements of OAR 436-060-0170 for the following purposes:

(a) To recover payments for permanent disability which were made prematurely;

(b) To recover overpayments for temporary disability; and

(c) To recover overpayments for other than temporary disability such as prepaid travel expenses where travel was not completed, prescription reimbursements, or other benefits payable under ORS 656.001 to 656.794.

(13) The insurer may allow overpayments made on a claim with the same insurer to be deducted from compensation to which the worker is entitled but has not yet been paid.

(14) Under ORS 656.268(10), if, after claim closure, the worker becomes enrolled and actively engaged in an authorized training plan under OAR 436-120, the insurer must again close the claim consistent with the following:

(a) The claim must be closed when the worker ceases to be enrolled and actively engaged in the training and:

(A) The worker is medically stationary;

(B) The worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions; or

(C) The claim otherwise qualifies for closure under OAR 436-030-0034.

(b) If the worker is medically stationary, there must be a current (within 60 days~~three months~~ before closure) determination of medically stationary status.

(c) For claims with dates of injury on or after January 1, 2005, permanent disability must be redetermined for work disability only. For claims with dates of injury before January 1, 2005, permanent disability must be redetermined for unscheduled disability only.

(d) Except for claims closed under ORS 656.268(1)(c), the insurer must have sufficient information to redetermine work disability or unscheduled disability. The requirements in section (2) of this rule regarding sufficient information apply only as necessary for the redetermination, as follows:

(A) For claims with dates of injury on or after January 1, 2005, the insurer must have sufficient information to determine work disability under OAR 436-035-0012. An evaluation of the adaptability factor of work disability under OAR 436-035-0012(7)

through (13) must be based on a current (within 60 days~~three months~~ before closure) medical determination of the worker's residual functional capacity.

(B) For claims with dates of injury before January 1, 2005, the insurer must have sufficient information to determine unscheduled disability under OAR 436-035-0008(2). An evaluation of unscheduled disability must be based on a current (within 60 days~~three months~~ before closure) medical determination.

(15) When, after a claim is closed, the insurer changes or is ordered to change the worker's weekly wage upon which calculation of the work disability portion of a permanent disability award may be based, the insurer must notify the parties and the division of the change and the effect of the change on any permanent disability award. For purposes of this rule, the insurer must complete Form 1502 consistent with the instructions of the director and distribute it within 14 days of the change.

Statutory authority: ORS 656.268 (OL2022, ch. 73, sections 4 & 5), 656.726
Statutes implemented: ORS 656.210, 656.212, 656.214, 656.268 (OL2022, ch. 73, sections 4 & 5), 656.726, 656.745
Hist: Amended 9/7/17 as WCD Admin. Order 17-056, eff. 10/8/17
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
Amended 12/19/22 as Admin. Order 22-068, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0035 Determining Medically Stationary Status

(1) A worker is medically stationary in the following circumstances:

(a) In initial injury claims. In an initial injury claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted conditions and direct medical sequelae of accepted conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(b) In new or omitted condition claims. In a new or omitted condition claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted new or omitted conditions and direct medical sequelae of accepted new or omitted conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(c) In aggravation claims. In an aggravation claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted worsened conditions and direct medical sequelae of accepted worsened conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(d) In occupational disease claims. In an occupational disease claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted occupational diseases and direct medical sequela of accepted occupational diseases are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(2) When there is a conflict in the medical opinions as to whether a worker is medically stationary, more weight is given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and clear and concise reasoning.

(3) Where there is not a preponderance of medical opinion stating a worker is or is not medically stationary, deference will generally be given to the opinion of the attending physician. However, in cases where expert analysis is important, deference is given to the opinion of the physician with the greatest expertise in, and understanding of, the worker's medical condition.

(4) When there is a conflict as to the date upon which a worker became medically stationary, the following conditions govern the determination of the medically stationary date. The date a worker is medically stationary is the earliest date that a preponderance is established under sections (1) and (2) of this rule. The date of the examination, not the date of the report, controls the medically stationary date.

(5) The insurer may request that the attending physician or authorized nurse practitioner concur with or comment on the closing examination when the attending physician or authorized nurse practitioner arranges or refers the worker for a closing examination with another physician. When the insurer closes a claim relying on an independent medical examination to support a preponderance of opinion establishing medically stationary status, before issuing the closure the insurer must request the attending physician or authorized nurse practitioner to concur with or comment on the independent medical examination. A concurrence with another physician's report is an agreement in every particular, including the medically stationary impression and date, unless the physician expressly states to the contrary and explains the reasons for disagreement. Concurrence cannot be presumed in the absence of the attending physician's response.

(6) A worker is medically stationary on the date so specified by a physician. When a specific date is not indicated, a worker is presumed medically stationary on the date of the last examination, prior to the date of the medically stationary opinion. Physician projected medically stationary dates cannot be used to establish a medically stationary date.

(7) If the worker is incarcerated or confined in some other manner and unable to freely seek medical treatment, the insurer must arrange for closing medical examinations to be completed at the facility where the worker is located or at some other location accessible to the worker.

(8) If a worker dies and the attending physician has not established a medically stationary date, for purposes of claim closure, the medically stationary date is the date of death.

(9) Notwithstanding any other provision of this rule, a physician or nurse practitioner may not retroactively determine a worker to be medically stationary more than 60 days prior to the date of the determination, except in the case of claims that are subject to ORS 656.268 (13). If the medically stationary date under sections (1), (4), (5), or (6) of this rule is more than 60 days prior to the date of the determination, the medically stationary date is the 60th day prior to the date of the determination.

Statutory authority: ORS 656.268(OL2022, ch. 73, sections 4 & 5), ORS 656.726

Statutes implemented: ORS 656.268 (OL2022, ch. 73, sections 4 & 5)
Hist: Amended 9/7/17 as WCD Admin. Order 17-056, eff. 10/8/17
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
Amended 12/19/22 as Admin. Order 22-068, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

Claims Administration
Oregon Administrative Rules
Chapter 436, Division 060

Effective Jan. 1, 2024

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
CLAIMS ADMINISTRATION

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 060

Revisions are marked: Added | ~~Deleted~~

436-060-0015 Required Notice and Information

(1) Notice to worker's attorney.

If a worker is represented by an attorney, and the attorney has given written notice of representation, the insurer must provide written notice to the worker's attorney before, or at the same time, as the insurer:

(a) Requests the worker to submit to a medical examination;

(b) Contacts the worker regarding any matter that may result in denial, reduction, or termination of the worker's benefits; or

(c) Contacts the worker regarding any matter relating to the disposition of a claim under ORS 656.236.

(2) Penalty for failure to provide notice to worker's attorney.

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

(3) Information provided to worker.

The insurer or service company must provide:

(a) Form 1138, "What happens if I'm hurt on the job?" to every worker who has a disabling claim with the first disability check or earliest written correspondence. For nondisabling claims, Form 3283, "A Guide for Workers Recently Hurt on the Job," may be provided in place of Form 1138, unless the worker specifically requests Form 1138;

(b) Form 3283 to its insured employers. Form 3283 may be printed on the back of Form 801;

(c) Form 3058, "Notice to Worker," or an equivalent form, to the worker with the initial notice of acceptance of the claim under OAR 436-060-0140(6). If an equivalent form is provided, it must include all of the information included on Form 3058;

(d) The additional notices 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; and

(e) With the first disability check or earliest written correspondence, contact information that will:

(A) Reasonably lead the worker to an Oregon certified claims examiner during regular Oregon business hours; and

(B) Reasonably ensure that inquiries from the worker are responded to within 48 hours, not including Saturday, Sunday, ~~weekends~~ or legal holidays under ORS 187.010 and 187.020.

(4) Notice of change of processing location.

When the insurer changes claims processing locations, service companies, or self-administration, the insurer must provide at least 10 days prior notice to workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, email address, and mailing address of the new claim processor.

(5) 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 insurer must provide a written explanation of any change to the worker and the worker's attorney, if any.

(6) Notice of wage used to calculate benefits at closure.

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

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

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

(c) Explains how the worker can appeal the insurer's wage calculation if the worker disagrees with the wage.

(7) Notice of end of temporary disability benefits.

In addition to other requirements in OAR chapter 436, the insurer may not end temporary disability benefits until written notice has been mailed or delivered to the worker and the worker's attorney, if the worker is represented. The notice must state the reason that temporary disability benefits are no longer due and payable.

(8) Notice of medically stationary status.

An insurer must mail or deliver a written notice to a worker and the worker's attorney, if the worker is represented, within seven days following receipt of information that the worker is medically stationary.

Statutory authority: ORS 656.331, 656.726(4), and 656.745
Statutes implemented: ORS 656.331, 656.262 (OL2022, ch. 73, sections 1 & 2), 656.268 (OL2022, ch. 73, sections 4 & 5), 656.726(4), and 656.745
Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
Amended 12/13/21 as WCD Admin. Order 21-056, eff. 1/1/22
Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0018 Nondisabling and Disabling Claim Reclassification

(1) General.

If the insurer changes the classification of an accepted claim, the insurer must:

(a) Notify the director under OAR 436-060-0011;

(b) Send the worker and the worker's attorney, if any, a "Modified Notice of Acceptance" explaining the change in status; and

(c) Close the claim under ORS 656.268(5), if the claim qualifies for closure.

(2) Reclassification of a nondisabling claim.

The insurer must reclassify a nondisabling claim to disabling:

(a) Within 14 days of receiving information that:

(A) Temporary disability is due and payable;

(B) The worker is medically stationary within one year of the date of injury and the worker will be entitled to an award of permanent disability; or

(C) The worker is not medically stationary, but there is a reasonable expectation that the worker will be entitled to an award of permanent disability when the worker does become medically stationary; or

(b) Upon acceptance of a new or omitted condition that meets the disabling criteria in this section.

(3) Worker request for reclassification.

A worker may request the insurer review the classification of a nondisabling claim under ORS 656.277 if 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 request for classification status review must be first made to the insurer in writing.

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

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

(B) If the insurer believes evidence supports denying the worker's request to reclassify the claim, the insurer must mail a "Notice of Refusal to Reclassify" to the worker and the worker's attorney, if any. The notice must include the following statement, in bold print:

"If you disagree with this Notice of Refusal to Reclassify, you may appeal by contacting the Workers' Compensation Division within sixty (60) days of the mailing date of this notice. You may appeal by using Form 2943, "Worker Request for Claim Classification Review," available on the division's website at wcd.oregon.gov.

Send written appeals to the Workers' Compensation Division, Appellate Review Unit, PO Box 14480, Salem OR 97309-0405

Or fax to: 503-947-7794

Or hand-deliver to: Workers' Compensation Division, Appellate Review Unit, 350 Winter Street NE, 2nd Floor, Salem OR 97301

You may appeal by phone by calling the Appellate Review Unit at 503-947-7816. A member of the Appellate Review Unit will complete and sign Form 2943 as the worker's designee and they will send a copy of the completed form to you, the insurer, and any attorneys involved in the claim.

If you do not appeal to the Workers' Compensation Division within 60 days of the mailing date of this notice, you will lose all rights to review of this decision. For assistance, you may call the Workers' Compensation Division at 503-947-7816, or the Ombuds Office for Oregon~~man for Injured~~ Workers at 503-378-3351 or 800-927-1271 (toll-free)."

(c) If the worker disagrees with the insurer's decision in the Notice of Refusal to Reclassify, the worker may appeal to the director under section (7) of this rule:

(A) The appeal must be made no later than the 60th day after the mailing date of the Notice of Refusal to Reclassify; and

(B) A copy of the insurer's Notice of Refusal to Reclassify must be provided to the director.

(d) If the insurer does not respond to the worker's request for reclassification within 14 days of receipt of the worker's request:

(A) The worker may request review by the director under section (7) of this rule as if the insurer issued a Notice of Refusal to Reclassify;

(B) The director may assess civil penalties under OAR 436-060-0200; and

(C) The director may assess an attorney fee under ORS 656.386(3).

(e) If the worker is represented by an attorney, and the attorney is instrumental in obtaining an order from the director that reclassifies the claim from nondisabling to disabling, the director may order a reasonable assessed attorney fee under ORS 656.277 and OAR 436-001-0435.

(4) Time frame for aggravation rights.

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

(a) The first valid closure of a claim that is reclassified from nondisabling to disabling within one year from the date of acceptance; or

(b) The date of injury of a claim that is not reclassified from nondisabling to disabling within one year from the date of acceptance.

(5) Claims for aggravation on nondisabling claims.

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 under ORS 656.273.

(6) Reclassification of a disabling claim.

If a claim has been accepted and classified as disabling:

(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 include the following:

"Notice to Worker: Your claim has been reclassified to nondisabling. Generally, this means your insurer concluded no disability payments are due and all of the following are true:

You were able to return to work at full wages on or before the fourth calendar day after leaving work or losing wages as a result of your injury.

You did not lose time or wages from work as a result of your injury on or after that fourth calendar day.

It appears you will not have any permanent disability as a result of your injury.

If you think there is a mistake in the classification of your claim as nondisabling, contact the insurer within one year of the date the insurer first accepted your claim and request reclassification.

If you request reclassification, the insurer must complete its review and send you its decision within 14 days of receiving your request. If you disagree with the insurer's decision, you have the right, within 60 days of the date of the insurer's notice, to request that the Workers' Compensation Division review your claim to determine if it was correctly classified. If the insurer does not respond to your request for reclassification within 14 days of receiving your request, you may ask the Workers' Compensation Division to review your claim as though the insurer refused to reclassify your claim. For assistance, you may call the Workers' Compensation Division at 503-947-7816, or the Ombuds Office for Oregon~~man for Injured~~ Workers at 503-378-3351 or 800-927-1271 (toll-free)."

(b) Any subsequently accepted conditions or aggravations must be processed as disabling claims; and

(c) Claim closure must be processed under ORS 656.268.

(7) Appeal of insurer's classification decision.

If a worker disagrees with an insurer's decision to not reclassify the worker's claim from nondisabling to disabling, the worker may appeal the decision by requesting review by the director:

(a) The request must be submitted to the division by mail, hand-delivery, fax, or phone within 60 days from the date of the insurer's notice;

(b) The worker may use Form 2943, "Worker Request for Claim Classification Review," for requesting review of the insurer's claim classification decision; and

(c) 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 must be copied to the insurer;

(B) The director will acknowledge receipt of the appeal in writing to the worker, the worker's attorney, if any, and the insurer, and initiate the review;

(C) Within 14 days of the director's acknowledgement:

(i) 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

(ii) The worker may submit any additional evidence for the director to consider. Copies must be provided to all other parties at the same time; and

(D) After receipt and review of the required documents, the director will issue an order:

(i) The worker and the insurer have 30 days from the mailing date of the order to appeal the director's decision to the board; and

(ii) The director may reconsider, abate, or withdraw any order before the order becomes final by operation of law.

Statutory authority: ORS 656.268, 656.277, 656.386, 656.726(4), and 656.745
Stats. Implemented: ORS 656.210, 656.212, 656.214, 656.262, 656.268, 656.273, 656.277, 656.386, and 656.745
Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
Amended 7/5/22 as WCD Admin. Order 22-063, eff. 9/1/22
Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0020 Payment of Temporary Total Disability Compensation

(1) Employer payment of temporary disability.

An employer may pay temporary disability compensation with the approval of the insurer. If the insurer approves an employer to make such payment:

(a) The insurer continues to be responsible for determining the worker's entitlement to compensation, and ensuring timely payment of compensation;

(b) The employer must provide the insurer with payment documentation that is adequate to meet the insurer's responsibilities; and

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

(2) Persons who have withdrawn from the workforce.

No temporary disability is due and payable for any period of time in which the person has withdrawn from the workforce. For the purpose of this rule, a person who has withdrawn from the workforce, includes, but is not limited to:

(a) A person who, before a claim reopening under ORS 656.267, 656.273 or 656.278, was not working and made no 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 before the date of 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 of temporary disability compensation.

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 when temporary disability benefits are not authorized by a medical service provider under ORS 656.245(2)(b). Temporary disability compensation is authorized when:

(a) The medical service provider 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, at reconsideration of claim closure, there is sufficient contemporaneous medical documentation to reasonably reflect the worker's inability to work under ORS 656.268.

(4) Lack of verification of inability to work.

No temporary disability is due and payable for any period of time 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, 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 ask the worker whether a reason beyond the worker's control prevented the worker from receiving treatment.

(A) If no valid reason is found or the worker does not respond or cannot be located, the insurer must document its file regarding those findings.

(B) The insurer must provide the director 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 not end~~stop~~ temporary disability

benefits~~payments~~ until written notice ~~is~~has been mailed or delivered under OAR 436-060-0015(7).~~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 receiving the verification of any authorized period of temporary disability, unless otherwise denied.

(5) Suspension of benefits.

An insurer may suspend temporary disability benefits without authorization from the director when all of the following circumstances apply:

(a) The worker missed a regularly scheduled appointment with the attending physician or authorized nurse practitioner;

(b) The insurer sent a letter by certified mail to the worker and a letter to the worker's attorney, at least 10 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) Verbal release to work.

If temporary disability benefits end because the insurer or employer negotiates a verbal release of the worker to return to any type of work with the worker's attending physician or authorized nurse practitioner, and the worker has not been informed of the release by the attending physician or authorized nurse practitioner or returned to work, the insurer must:

(a) Document the facts;

(b) Communicate the release to the worker by mail within 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) Temporary disability from two or more claims.

When a worker is due concurrent temporary disability under ORS 656.210 or ORS 656.212 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 insurers may request for the director to make a pro rata distribution of compensation due. The request must be in writing, and the insurer must provide a copy to the worker and the worker's attorney, if any;

(c) The director's pro rata order does not apply to:

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

(B) Any benefits due under ORS 656.214 or 656.245;

(d) Claims subject to the pro rata order must be closed under OAR 436-030 and ORS 656.268, when appropriate;

(e) The pro rata distribution ordered by the director only applies 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;

(f) The insurers may not prorate temporary disability without the approval of the director, except when the claims involve the same worker, the same employer, and the same insurer. When the insurer prorates temporary disability under this subsection the worker must receive compensation at the highest temporary disability rate of the claims involved.

(8) 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.

(9) Incorrectly denied claims.

If a denied claim has been determined to be compensable by final order, the insurer must begin temporary disability payments under ORS 656.262, including retroactive periods, if the 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 (OL2022, ch. 73, sections 1 & 2), and 656.726(4)
Statutes implemented: ORS 656.210, 656.212, 656.245, 656.262 (OL2022, ch. 73, sections 1 & 2), and 656.307
Hist: Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/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 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) The worker must have the opportunity to dispute the suspension of compensation before the director will issue the order; and

(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.

(c) Any action of a worker's observer allowed under OAR 436-010-0265(6) that obstructs the examination may be considered an obstruction of the examination by the worker for the purpose of this rule.

(d) The director may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination.

(e) The director may impose a monetary penalty against the worker under OAR 436-010-0265.

(2) Number of examinations.

The insurer may request no more than three separate independent medical examinations for each opening 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).

(3) Scheduling and notice to worker.

The insurer may contract with a third party to schedule independent medical examinations. When an examination is scheduled by the insurer, or by a third party at the request of the insurer:

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

(b) The notice must be mailed at least 10 days 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) The name of the examiner or facility;

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

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

(D) The first and last name of the attending physician or authorized nurse practitioner and verification that the attending physician or authorized nurse practitioner was informed of the examination by, at least, a copy of the appointment notice, or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;

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

(F) A statement that the reasonable cost of public transportation or use of a private vehicle will be reimbursed and that, when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance;

(G) A statement that an amount will be paid equivalent to net lost wages for the period during which it is necessary to be absent from work to attend the medical examination if benefits are not received under ORS 656.210(4) during the absence;

(H) A statement that the worker has the right to have an observer present at the examination, but the observer may not be compensated in any way for attending the exam; however, for a psychological examination, the notice must explain that an observer is allowed to be present only if the examination provider approves the presence of an observer; and

(I) The following notice in prominent or bold face type:

"You must attend this examination. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the examination. If you fail to attend and do not have a good reason for not attending, or you fail to cooperate with the examination, your workers' compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.325 and OAR 436-060. You may be charged a $100 penalty if you fail to attend without a good reason or if you fail to notify the insurer before the examination. The penalty is taken out of future benefits.

If you object to the location of this appointment you must contact the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 or the Ombuds Office for Oregon~~man for Injured~~ Workers at 1-800-927-1271."

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

(A) Form 3921, "Request for Reimbursement of Expenses," or a similar form for requesting reimbursement; and

(B) Form 3923, "Important Information about Independent Medical Exams."

(4) Reimbursement of costs.

When a worker attends an independent medical examination the insurer must reimburse the worker for reasonable costs in accordance with OAR 436-009-0025 regardless of claim acceptance, deferral, or denial.

(5) Forwarding of reports from provider.

Following completion of the examination, the insurer must forward a copy of the examiner's signed report to the attending physician or authorized nurse practitioner within three business days of the insurer's receipt of the report.

(6) 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 a summons. The request must include the following information:

(a) That the insurer requests suspension of 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 attorney will be sufficient documentation with which to request suspension;

(h) A copy of the notice required in section (3) and a copy of any written verification received under subsection (6)(g) of this rule;

(i) Any other information 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 within 10 days of the date this request was mailed or personally served on you. 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."

(7) Effective date of suspension.

If the director authorizes the suspension of compensation, the suspension will be effective from the date the worker fails to attend an examination or such other date the 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.

(8) 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.

(9) 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.

(10) Denial of suspension.

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

(11) Other actions by the director.

The director may also take the following actions concerning the suspension of compensation:

(a) Modify or set aside the order of consent before or after a request for hearing is filed;

(b) Order payment of compensation previously suspended when the director finds the suspension to have been made in error; and

(c) Reevaluate the necessity of continuing a suspension.

(12) 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 board.

Statutory authority: ORS 656.325, 656.704, and 656.726(4)
Statutes implemented: ORS 656.325, 656.704, and 656.726(4)

Hist: Amended 12/14/17 as WCD Admin. Order 17-062, eff. 1/1/18
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/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. Insurers that fail to obtain authorization from the director for additional vocational evaluations may be assessed a civil penalty.

(a) To request authorization the insurer must:

(A) Submit a written request for authorization that includes:

(i) The reasons for an additional vocational evaluation;

(ii) The conditions to be evaluated;

(iii) The dates, times, places, and purposes of previous evaluations;

(iv) Copies of previous vocational evaluation notification letters to the worker; and

(v) Any other information requested by the director;

(B) Provide a copy of the request to the worker and the worker's attorney, if any.

(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.

(c) The director's decision approving or denying more than three vocational evaluations may be appealed to the board within 60 days of the order.

(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.

(3) Notice to worker.

The insurer must notify the worker of the evaluation at least 10 days before the date of evaluation.

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

(A) The name of the vocational assistance provider or facility;

(B) A statement of the specific purpose for the evaluation;

(C) The date, time and place of the evaluation;

(D) The first and last name of the attending physician or authorized nurse practitioner or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;

(E) If applicable, confirmation that the director has approved the evaluation;

(F) Notice to the worker that the reasonable cost of public transportation or use of a private vehicle will be reimbursed; when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed; a request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request; should an advance of costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance; and

(G) The following notice in prominent or bold face type:

"You must attend this vocational evaluation. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the evaluation. If you do not attend or 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 Ombuds Office for Oregon~~man 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.

(4) Reimbursements of costs.

The insurer must pay the costs of the vocational evaluation and related services 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.

(5) 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, the director may suspend the worker's compensation by order, under the following conditions:

(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:

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

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

(C) The dates of any prior vocational evaluations the worker has attended and the names of the vocational assistance provider or facilities, or a statement that there have been no prior evaluations, whichever is appropriate;

(D) A copy of any approvals given by the director for more than three vocational evaluations, or a statement that no approval was necessary, whichever is appropriate;

(E) Any reasons given by the worker for failing to attend, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;

(F) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the vocational evaluation received by the insurer from the worker or the worker's attorney will be sufficient documentation with which to request suspension;

(G) A copy of the letter required in section (3) of this rule and a copy of any written verification received under paragraph (F) of this subsection;

(H) Any other information that supports the request; and

(I) The following notice in prominent or bold face type:

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. If the division grants this request, you may lose all or part of your benefits."

(c) If the director suspends compensation:

(A) The suspension will be effective from the date the worker fails to attend a vocational evaluation or such other date the director 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;

(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;

(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; and

(F) The director may re-evaluate 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; and

(e) 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 board.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.206
Hist: Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0147 Worker Requested Medical Examination

(1) Eligibility.

The worker is eligible for a worker requested medical examination if:

(a) The worker has made a timely request for a board hearing on a denial of compensability;

(b) The denial is based on one or more independent medical examination reports; and

(c) The attending physician or authorized nurse practitioner does not concur with the report or reports.

(2) Request for exam.

The worker must submit a request for the exam to the division. A copy of the request must be sent simultaneously to the insurer.

(a) The request must include:

(A) The name, address, and claim identifying information of the worker;

(B) A list of physicians, including names and addresses, who have previously provided medical services to the worker on the claim, or who have previously provided medical services to the worker related to the claimed conditions;

(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) Documents that demonstrate that the attending physician or authorized nurse practitioner does not concur with the independent medical examination report or reports, if available.

(b) The director will determine the worker is eligible for an exam if the eligibility criteria in section (1) of this rule are met and:

(A) The worker or insurer provides documents that demonstrate that the attending physician or authorized nurse practitioner does not concur with the independent medical examination report or reports; or

(B) The director has not received documents that demonstrate the attending physician or authorized nurse practitioner does or does not concur with the report or reports, and at least 30 days after the worker's request for hearing under subsection (1)(a) of this rule have passed.

(3) Required documentation.

The insurer must send 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 requested by the insurer under ORS 656.325; or

(d) Reviewed the worker's medical records on the claim.

(4) Penalty for failure to provide documentation.

Failure to provide the required documentation described in section (3) of this rule in a timely manner may subject the insurer to civil penalties under OAR 436-060-0200.

(5) Selection of physicians.

If the director determines the worker is eligible for the exam, the director will notify all parties in writing of the physician selected, or will provide the worker or the worker's attorney a list of appropriate physicians. If the director provides a list of physicians, the following applies:

(a) The worker's or the worker's attorney's response must be in writing, signed, and delivered to the director within 14 days of the mailing date of the list;

(b) The worker or the worker's attorney may eliminate the name of one physician from the list;

(c) If the worker or the worker's attorney does not respond as provided in this section, the director will select a physician; and

(d) The director will notify the parties in writing of the physician selected.

(6) Scheduling the exam.

The worker or the worker's attorney must schedule the exam with the selected physician, and notify the insurer and the board of the scheduled exam date within 14 days of the date of the director's notice in section (5) of this rule. The exam is not required to take place within the

14-day notification period. An unrepresented worker may consult with the Ombuds Office for Oregon~~man for Injured~~ Workers for assistance.

(7) Required medical records.

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

(8) Exam questions.

The worker, or the worker's attorney, 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 before the scheduled date of the exam. An unrepresented worker may consult with the Ombuds Office for Oregon~~man for Injured~~ Workers for assistance.

(9) Physician's response.

Upon completion of the exam the physician must address the original independent medical examination questions and the questions from the worker or the worker's attorney under section (8) of this rule and send the report to the worker's attorney, if any, or the worker, and the insurer within 14 days.

(10) Payment of physician.

The insurer must pay the physician selected under this rule in accordance with OAR 436-009. Medical services to workers must be delivered in accordance with OAR 436-010.

(11) Failure to attend exam.

If the worker does not attend the scheduled worker requested medical exam, the insurer must pay the physician for the missed exam under OAR 436-009-0010(13). The insurer is not required to pay for another exam unless the worker did not attend the missed examination for reasons beyond the worker's reasonable control.

(12) Reimbursement for services.

The insurer must reimburse the worker for all necessary related services under ORS 656.325(1).

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.325(1)
Hist: Amended 12/14/17 as WCD Admin. Order 17-062, eff. 1/1/18
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0170 Recovery of Overpayment of Benefits

(1) Benefits paid a worker.

An insurer may only recover overpayment of benefits paid to a worker as specified by ORS 656.268(14) and (16), unless authority is granted by an administrative law judge or the board.

(2) Benefits due a worker.

An insurer may recover an overpayment from any benefits currently due on any claim the worker has with that insurer. The insurer must explain in writing the reason, the amount, and the method of recovery to the worker and the worker's attorney, if any, or to the worker's beneficiaries.

(3) Permanent partial disability offsets.

When overpaid benefits are offset against monthly permanent partial disability award payments, the insurer must recover the benefits from the total amount of the award. The insurer must pay out the remainder of the award at 4.35 times the temporary total disability rate, or at least $108.75, starting with the first month's payment.

Statutory authority: ORS 656.726(4);
Statutes implemented: ORS 656.268(13),~~and~~ (14), and (16) (OL2022, ch. 73, sections 4 & 5)
Hist: Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

Vocational Assistance to Injured Workers
Oregon Administrative Rules
Chapter 436, Division 120

Effective Jan. 1, 2024

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Historical rules: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 120

Revisions are marked: Added | ~~Deleted~~.

436-120-0012 General Requirements for Notices and Warnings

(1) Insurer or provider may issue.

The insurer is responsible for mailing all notices and warnings required by these rules but may delegate that responsibility to the provider that is providing vocational assistance to the worker.

(2) Required content.

All notices and warnings to the worker issued under these rules must:

(a) Use the applicable heading. If a notice is used for more than one purpose, it must include all the headings that apply;

(b) Be in writing, signed, and dated;

(c) State the basis for the decision;

(d) Include the effective date of each action in the heading;

(e) Cite the relevant rules;

(f) Include the worker's appeal rights. All notices and warnings except those notifying a worker of entitlement to training or deferral of vocational assistance eligibility must contain the worker's appeal rights in bold type, as follows:

"If you disagree with this decision, you should contact [insert the person's name and the insurer name] within five days of receiving this letter to discuss your concerns. If you are still dissatisfied, you must contact the Workers' Compensation Division within 60 days of receiving this letter or you will lose your right to appeal this decision. A consultant with the division can talk with you about the disagreement and, if necessary, will review your appeal. The address and telephone number of the division are: Employment Services Team, Workers' Compensation Division, P.O. Box 14480, Salem, Oregon 97309-0405; 1-800-452-0288."; and

(g) Include the telephone number of the Ombuds Office for Oregon~~man for Injured~~ Workers: 1-800-927-1271.

(3) Mailing and copies.

All notices and warnings must:

(a) Be mailed to the worker's last known address by both regular and certified mail; and

(b) Be copied to the division and worker's attorney, if any, at the same time the notice or warning is mailed to the worker.

(4) Effective date.

A notice is not effective until it is sent to all required parties including the worker's attorney.

(5) Requirements for warning letters.

(a) A warning letter can be issued at any time during the vocational eligibility evaluation or vocational assistance process.

(b) Warning letters do not require specific language in the headings but must include a heading clearly indicating the purpose of the warning.

(c) A warning letter must state what the worker must do, and by when, to avoid ineligibility or the ending of eligibility or training.

Statutory authority: ORS 656.340(9), 656.726(4)
Statutes implemented: ORS 656.340
Hist: Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012
Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17
Amended 12/19/22 as Admin. Order 22-070, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0443 Training - General

(1) Training services include but are not limited to plan development, training, monthly monitoring of training progress, and job placement services.

(2) The training plan must be developed and monitored by a counselor.

(3) The selection of plan objectives and the kind of training must attempt to minimize the length and cost of training necessary to prepare the worker for suitable employment.

(4) If there are any changes made to the original training plan, an addendum to Form 1081, "Training Plan," must be completed, signed by all parties, and submitted to the division.

(5) Basic education may be offered, with or without other training components, to raise the worker's education to a level to enable the worker to obtain suitable employment.

(6) On-the-job training prepares the worker for permanent, suitable employment with the training employer and for employment in the labor market at large. On-the-job training must be considered first in developing a training plan.

(7) Occupational skills training is offered through a community college, based on a predetermined curriculum, at the training employer's location.

(8) Formal training may be offered through a vocational school licensed by an appropriate licensing body, community college, or other post-secondary educational facility that is part of a state system of higher education.

(9) Rehabilitation facilities training provides evaluation, training, and employment for severely disabled individuals.

(10) Notwithstanding OAR 436-120-0145(2)(b), the director may order the insurer, or the insurer may elect, to provide training outside Oregon if such training would be more timely, appropriate, or cost effective than other alternatives.

(11) Training status continues during the following breaks:

(a) A regularly scheduled break of not more than six weeks between fixed school terms;

(b) A break of not more than two weeks between the end of one kind of training and the start of another for which the starting date is flexible; or

(c) A period of illness or recuperation of the worker that does not prevent completion of the training by the planned date.

(12) The insurer must pay the worker temporary disability compensation, under ORS 656.268 and 656.340, when the worker is actively engaged in an approved training plan and there is a Form 1081, "Training Plan," signed by the worker, the insurer, and the counselor who developed the plan.

(13) Temporary disability compensation is limited for each eligibility period to 16 months unless extended to 21 months by the insurer or ordered by the director when the worker provides good cause. Good cause may include but is not limited to the reasons given under section (15~~14~~) of this rule. In no event may temporary disability compensation during training be paid for more than 21 months.

(14) In addition to other requirements in OAR chapter 436, the insurer may not end temporary disability benefits until written notice under OAR 436-060-0015(7) has been mailed or delivered to the worker and the worker's attorney, if the worker is represented.

(15~~14~~) Training costs may be paid for periods longer than 21 months. Reasons for extending training may include but are not limited to:

(a) Reasons beyond the worker's control;

(b) The worker has an exceptional disability, which is a disability equal to or greater than the complete loss, or loss of use, of both legs, or a brain injury that results in impairment equal or greater than Class 3 as defined in OAR 436-035-0390; or

(c) The worker has an exceptional loss of earning capacity, which exists when no suitable training plan of 18 months or less will eliminate the worker's substantial handicap to employment. The extension must allow the worker to obtain, at the time of completion of the training program, a wage that is as close as possible to the worker's adjusted weekly wage and greater than could be expected with a shorter training program.

(16~~15~~) An eligible worker is entitled to four months of job placement assistance after completion of training.

(17~~16~~) When the worker returns to work following training, the insurer must monitor the worker's progress for at least 60 days to assure the suitability of the employment before ending eligibility.

(18~~17~~) If the worker chooses a training plan period longer than the worker is entitled to receive under these rules, the worker may supplement training provided by the insurer by

completing self-sponsored training or studies. For the purpose of this rule, self-sponsored means the worker is obligated to pay for the training.

(a) The first day of training provided by the insurer will be considered the training start date and the last day of training provided by the insurer will be the training end date.

(b) All self-sponsored training must be completed before the training start date unless the parties otherwise agree.

(c) During self-sponsored training, the insurer may provide optional services under OAR 436-120-0187, including but not limited to payment of expenses for tuition, fees, books, and supplies.

(d) The training plan support document must describe how the worker-sponsored training and the training provided by the insurer will combine to prepare the worker for suitable employment.

(19~~8~~) The insurer must provide further training to a worker if the initial plan will not be or was not successful to prepare the worker for suitable employment.

Statutory authority: ORS 656.340(9), 656.726(4)
Statutes implemented: ORS 656.340, 656.262 (OL2022, ch. 73, sections 1 & 2)
Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17
Amended 6/13/22 as Admin. Order 22-060, eff. 7/1/22
Amended 12/19/22 as Admin. Order 22-070, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.