

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION



**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**

Summary of changes effective Jan. 1, 2024:

- 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.

436-030-0003 Purpose, Applicability, Forms, and Bulletins

(1) Purpose. The purpose of the rules in OAR 436-030 is to provide standards, conditions, procedures, and reporting requirements for:

- (a) Requests for closure by the worker;
- (b) Claim closure under ORS 656.268(1);
- (c) Determining medically stationary status;
- (d) Determining temporary disability benefits;

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- (e) Awards of permanent partial disability;
- (f) Determining permanent total disability awards;
- (g) Review for reduction of permanent total disability awards;
- (h) Review of prior permanent partial disability awards; and
- (i) Reconsideration of notices of closure.

(2) Applicability of rules.

- (a) Except as provided in subsections (b) and (c) of this section, the rules in OAR 436-030 apply to all accepted claims for workers' compensation benefits and all claims closed on or after the effective date of these rules.
- (b) All orders the division issues to carry out the statute and the rules in OAR 436-030 are considered orders of the director.
- (c) For claims in which the worker became medically stationary before July 2, 1990, OAR 436-030-0020, 436-030-0030, and 436-030-0050 as adopted by WCD Administrative Order 13-1987, effective January 1, 1988, will apply.
- (d) OAR 436-030-0055(3)(b), (3)(d), and (4)(a) apply to all claims with dates of injury on or after January 1, 2002.
- (e) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(3) Availability of forms and bulletins. The forms and bulletins referenced in these rules are available on the division's website at <https://wcd.oregon.gov/forms/Pages/forms.aspx> and <https://wcd.oregon.gov/forms/Pages/bulletins.aspx>.

Statutory authority: ORS 656.268, 656.726

Statutes implemented: ORS 656.005, 656.206, 656.210, 656.212, 656.214, 656.262, 656.268, 656.273, 656.278, 656.325, 656.726

Hist: Amended 2/12/15 as WCD Admin. Order 15-057, eff. 3/1/15

Amended 4/10/17 as WCD Admin. Order 17-053 (temporary/expired), eff. 4/11/17 through 10/7/17

Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0005 Definitions

Unless a term is defined in these rules or the context otherwise requires, the definitions of ORS chapter 656 are incorporated by reference and made part of these rules.

- (1) "**Authorized nurse practitioner**" means a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010.
- (2) "**Board**" means the Workers' Compensation Board and includes its Hearings Division.
- (3) "**Day**" means calendar day unless otherwise specified (e.g., "working day").
- (4) "**Direct medical sequela**" means a condition that is clearly established medically and originates or stems from an accepted condition.
- (5) "**Director**" means the director of the Department of Consumer and Business Services, or the director's designee.

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- (6) "**Division**" means the Workers' Compensation Division of the Department of Consumer and Business Services.
- (7) "**Instant fatality**" means a compensable claim for death benefits when the worker dies within 24 hours of the injury.
- (8) "**Insurer**" means the State Accident Insurance Fund; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon, a self-insured employer, or a self-insured employer group.
- (9) "**Irreversible findings**" has the same meaning as described in OAR 436-035-0005(7).
- (10) "**Mailed**" or "**mailing date**," for the purposes of determining timeliness under these rules, means the date a document is postmarked. Requests submitted by fax will be considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date received by the division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.
- (11) "**Notice of Closure**" means a notice to the worker, estate, or beneficiary issued by the insurer to:
- (a) Close an accepted disabling claim, including fatal claims;
 - (b) Correct, rescind, or rescind and reissue a Notice of Closure previously issued; or
 - (c) Reduce permanent total disability to permanent partial disability.
- (12) "**Reconsideration**" means review by the director of an insurer's Notice of Closure.
- (13) "**Statutory closure date**" means the date the claim satisfies the criteria for closure under ORS 656.268(1)(b) and (c).
- (14) "**Statutory appeal period**" means the time frame for appealing a Notice of Closure or Order on Reconsideration.
- (15) "**Work disability**," for purposes of determining permanent disability, means the separate factoring of impairment as modified by age, education, and adaptability to perform the job at which the worker was injured.

Statutory authority: ORS 656.268, 656.726
 Statutes implemented: ORS 656.005, 656.268, and 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
 See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0007 Administrative Review

- (1) Notices of Closure issued by insurers are appealed to the director and processed in accordance with the reconsideration procedures described in OAR 436-030-0115 through OAR 436-030-0185, except Notices of Closure under (3)(b) of this rule, when:
- (a) The worker was determined medically stationary after July 1, 1990; or
 - (b) The claim qualifies for closure under ORS 656.268(1)(b) or (c).

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- (2) The director may abate, withdraw, or amend the Order on Reconsideration during the 30-day appeal period for the Order on Reconsideration.
- (3) The following matters are brought before the board:
- (a) Orders on Reconsideration issued under these rules.
 - (b) Notices of Closure that rescind permanent total disability under ORS 656.206.
 - (c) Any other action taken under these rules where a worker's right to compensation or the amount thereof is directly an issue under ORS chapter 656.
- (4) Contested Case Hearings of Sanctions and Civil Penalties: Under ORS 656.740, any party aggrieved by a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254, 656.735, 656.745 or 656.750 may request a hearing by the board as follows:
- (a) The party must send the request for hearing in writing to the director within 60 days after the mailing date of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested.
 - (b) The division will forward the request and other pertinent information to the board.
 - (c) An Administrative Law Judge from the board, acting on behalf of the director, will conduct the hearing in accordance with ORS 656.740 and ORS Chapter 183.
- (5) Director's Administrative Review of other actions: Except as covered under sections (1) through (4) of this rule, any party seeking an action or decision by the director or aggrieved by an action taken by any other party under these rules, may request administrative review by the director subject to the following:
- (a) The party must send the request in writing to the director within 90 days of the disputed action and must specify the grounds upon which the action is disputed; and
 - (b) The director may require and allow such evidence as is deemed appropriate to complete the review.

Statutory authority: ORS 656.268, 656.726

Statutes implemented: ORS 656.268, 656.726, 656.740

Hist: Amended 12/1/2009 as WCD Admin. Order 09-056 eff. 1/1/2010

Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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

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(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.

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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 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

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- (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 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.

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436-030-0017 Requests for Claim Closure by the Worker

(1) A worker may request claim closure from the insurer. The insurer must issue a Notice of Closure or Notice of Refusal to Close within 10 days of receipt of a written request for claim closure from the worker or the worker's attorney.

(2) If an insurer issues a Notice of Refusal to Close, the notice must be clearly titled "Notice of Refusal to Close" and it must include:

- (a) Name of the worker;
- (b) Date of injury;
- (c) Insurer's claim number;
- (d) Mailing date of the notice;
- (e) The accepted and denied conditions;
- (f) Rationale for the insurer's decision; and
- (g) The following language, in bold print:

"If you disagree with this Notice of Refusal to Close your claim, you must file a letter of disagreement with the Workers' Compensation Board within sixty (60) days from the date of this notice. Your letter must state that you want a hearing, note your address, and include the date of your accident if known. You must mail your letter of disagreement to the Workers' Compensation Board, 2601 25th Street SE, Suite 150, Salem, OR 97302-1280. If your claim qualifies and you request it, you may receive an expedited hearing (within 30 days). Your request cannot, by law, affect your employment. If you do not file your letter of disagreement within sixty (60) days from the date of this notice, your hearing will be denied as the appeal time has passed. You may be represented by an attorney if you choose."

(3) If the worker disagrees with the Notice of Refusal to Close, the worker may request a hearing from the board.

Statutory authority: ORS 656.268, 656.726

Statutes implemented: ORS 656.268, 656.319, 656.726, 656.745,

Hist: Amended 12/1/2009 as WCD Admin. Order 09-056 eff. 1/1/2010

Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

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;

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(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;

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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

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(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

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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;

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- (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 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

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- (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.

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(b) If the worker is medically stationary, there must be a current (within 60 days 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 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 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.

436-030-0023 Correcting and Rescinding Notices of Closure

(1) An insurer may rescind or correct its Notice of Closure prior to the expiration of the appeal period for that notice and prior to or on the same day that the director receives a request for reconsideration of the Notice of Closure.

(2) The form, format, and completion of the Correcting and Rescinding Notices of Closure are the same as those of the Notice of Closure except that, to correct a Notice of Closure, a [Form 1644c](#) must be used and, to rescind a Notice of Closure, a [Form 1644r](#) must be used. An insurer may rescind and reissue a Notice of Closure by using a Form 1644 when such actions can be accomplished at the same time, the claim remains closed, and other provisions of these rules are met.

(3) The "Date of closure (mailing date)" on the Correcting or Rescinding Notice of Closure must be the date the correction or rescission is mailed. The mailing date of the Notice of

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Closure being rescinded or corrected must be identified within the body of the Correcting or Rescinding Notice of Closure.

(4) The worker's copy of the Correcting and Rescinding Notices of Closure must be mailed by both regular mail and certified mail return receipt requested, consistent with OAR 436-030-0020(8) and (10).

(5) Rescinding Notices of Closure, [Form 1644r](#), are used to rescind the Notice of Closure and return the claim to open status. Examples of appropriate uses of Rescinding Notices of Closure include, but are not limited to:

(a) The worker was not medically stationary at the time the Notice of Closure was issued; and

(b) The closure was otherwise premature.

(6) The Rescinding Notice of Closure must:

(a) Advise the worker that the claim remains open and no aggravation rights end date has been established, if it is rescinding the first closure of the claim;

(b) Initiate an appeal period as provided in OAR 436-030-0145(1) during which any request for reconsideration must be received by the director;

(c) Explain the reason for the action being taken; and

(d) Be distributed and mailed to the parties consistent with these rules.

(7) When a Notice of Closure granting only temporary disability has been issued, if the insurer determines the worker's medically stationary status is unchanged and the worker is entitled to an award of permanent disability, the insurer must use a Notice of Closure, Form 1644, to rescind and reissue the closure. In such cases, the Notice of Closure must:

(a) Contain all required information consistent with these rules;

(b) Bear the heading "Rescind and Reissue";

(c) Explain the reason the action is being taken;

(d) Identify the permanent disability award being granted consistent with OAR 436-030 and 436-035;

(e) Establish a new appeal period as provided in OAR 436-030-0145(1);

(f) Set a new aggravation rights end date if the Notice of Closure being rescinded is the first closure of the claim; and

(g) Be distributed and mailed to the parties consistent with these rules.

(8) Correcting Notices of Closure, [Form 1644c](#), are used to correct errors or omissions and do not change the closure status or the action taken by the Notice of Closure being corrected. Correcting Notices of Closure may not be used to grant permanent disability in claims where the Notice of Closure being corrected did not include an award of permanent disability.

Examples of appropriate uses of Correcting Notices of Closure include, but are not limited to:

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- (a) Permanent disability award computation errors (dollars, degrees, percentages);
 - (b) An incorrect "mailing date";
 - (c) Return-to-work status errors or omissions; and
 - (d) Incorrect or incomplete statement of temporary disability.
- (9) A Correcting Notice of Closure must:
- (a) Be issued when the director has instructed the insurer to do so because the Notice of Closure did not contain the information required by OAR 436-030-0020(4);
 - (b) Not be used to add a new condition to the claim closure, rate a new condition not considered in the Notice of Closure being corrected, or rescind a Notice of Closure;
 - (c) State in the body of the correcting notice only the information being corrected on the Notice of Closure and the basis for the correction;
 - (d) Not change the appeal period for the Notice of Closure being corrected; and
 - (e) Initiate a new appeal period as provided in OAR 436-030-0145(1) during which any request for reconsideration must be received, but only for those items being corrected.

Statutory authority: ORS 656.268, ORS 656.726

Statutes implemented: ORS 656.210, 656.212, 656.214, 656.268, 656.270, 656.726, 656.745

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

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0034 Administrative Claim Closure

- (1) The insurer must close a claim when the worker is not medically stationary and the worker fails to seek treatment for more than 30 days without the instruction or approval of the attending physician or authorized nurse practitioner and for reasons within the worker's control. In order to close a claim under this section, the insurer must:
- (a) Wait for the 30-day lack of treatment period to expire or any additional time period recommended by the attending physician or authorized nurse practitioner before sending the worker written notification by certified and regular mail, with a copy sent to the worker's attorney if the worker is represented, informing the worker of the following:
 - (A) The worker's responsibility to seek medical treatment in a timely manner;
 - (B) The consequences for failing to seek treatment in a timely manner which include, but are not limited to, claim closure and possible loss or reduction of a disability award; and
 - (C) The claim will be closed unless the worker establishes within 14 days from the date the letter was sent certified mail that:
 - (i) Treatment has resumed by attending an existing appointment or scheduling a new appointment; or
 - (ii) The reasons for not treating were outside the worker's control.

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(b) Wait the 14-day period given in the notification letter to allow the worker to provide evidence that the lack of treatment was either authorized by the attending physician or authorized nurse practitioner or beyond the worker's control.

(c) Determine whether claim closure is appropriate based on the information received.

(d) Rate all permanent disability apparent in the record at the time of claim closure. This includes, but is not limited to, any irreversible findings.

(e) Use 30 days from the last treatment provided or any additional time period authorized by the attending physician or authorized nurse practitioner as the date the claim qualifies for closure on the Notice of Closure.

(2) Regardless of whether the worker is medically stationary, the insurer must close a claim when a worker has not sought treatment for more than 30 days with a health care provider authorized under ORS 656.005 and ORS 656.245 (e.g., a worker enrolled in a managed care organization (MCO) who treats with a physician outside the MCO is not treating with an authorized health care provider). To close a claim under this section, the insurer must follow the requirements in section (1) of this rule and inform the worker that the reason for the impending closure is because the worker failed to treat with an authorized health care provider.

(3) A claim must be closed, regardless of whether the worker is medically stationary, when the worker fails to attend a mandatory closing examination for reasons within the worker's control. To close a claim under this section, the insurer must:

(a) Inform the worker in writing sent by certified and regular mail, with a copy sent to the worker's attorney if the worker is represented, at least 10 days prior to the mandatory closing examination of:

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

(B) The worker's responsibility to attend the examination;

(C) The consequences for failing to attend, which include, but are not limited to, claim closure and the possible loss or reduction of a disability award; and

(D) The worker's responsibility to provide, within seven days from the date of the scheduled examination, information to the insurer regarding why the examination was not attended, if the reason was beyond the worker's control.

(b) Wait seven days from the date of the missed examination to allow the worker to demonstrate good cause for failing to attend before closing the claim.

(c) Rate all permanent disability apparent in the record at the time of claim closure. This includes, but is not limited, to any irreversible findings.

(d) Use the date of the failed mandatory closing examination as the date the claim qualifies for closure on the Notice of Closure.

(4) The insurer may close the claim under section (1) of this rule, regardless of whether the worker is medically stationary, when a closing examination has been scheduled between a worker and attending physician directly and the worker fails to attend the examination.

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(5) A claim may be closed when the worker's otherwise compensable injury is not medically stationary and a major contributing cause denial has been issued on an accepted combined condition.

(a) The major contributing cause denial must inform the worker that claim closure may result from the issuance of the denial and provide all other information required by these rules.

(b) When a major contributing cause denial has been issued following the acceptance of a combined condition, the date the claim qualifies for closure is the date the insurer receives sufficient information to determine the extent of any permanent disability under OAR 436-030-0020(2) or the date of the denial, whichever is later.

(6) When two or more of the above events occur concurrently, the earliest date the claim qualifies for closure is used to close the claim.

(7) The attending physician or authorized nurse practitioner, if the worker has one, must be copied on all notification and denial letters applicable to this rule.

(8) When the director has issued a suspension order under OAR 436-060-0095 or OAR 436-060-0105, the date the claim qualifies for closure is the date of the suspension order.

Statutory authority: ORS 656.262, 656.268, 656.726

Statutes implemented: ORS 656.268, 656.726

Hist: Amended 1/29/15 as Admin. Order 15-052, eff. 3/1/15

Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

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

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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

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(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.

436-030-0036 Determining Temporary Disability

(1) Temporary disability must be determined under ORS chapter 656, OAR 436-060, and this rule, less time worked. Beginning and ending dates of each authorized period of temporary total disability and temporary partial disability must be noted on the Notice of Closure, as well as the statements "Less time worked" and "Temporary disability was determined in accordance with the law."

(2) Except as provided in section (3) of this rule and ORS 656.268(10), a worker is not entitled to any award of temporary disability for any period of time in which the worker is medically stationary.

(3) Awards of temporary disability must include the day the worker is medically stationary or the date the claim otherwise qualifies for closure, unless temporary disability is not authorized for another reason at that time.

Statutory authority: ORS 656.268, 656.726

Statutes implemented: ORS 656.005, 656.160, ORS 656.210, 656.212, 656.236, 656.245, 656.262, 656.268, 656.726

Hist: Amended 10/26/04 as WCD Admin. Order 04-062, eff. 1/1/05

Amended 11/17/11 as WCD Admin. Order 11-058, eff. 1/1/12

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0038 Permanent Partial Disability

The standards developed under ORS 656.726(4) and contained in OAR 436-035 must be applied when evaluating a worker's permanent partial disability.

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

Statutes implemented: ORS 656.214, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313

Hist: Amended 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0055 Determining Permanent Total Disability

(1) A worker is permanently and totally disabled if permanently incapacitated from regularly performing work in a suitable and gainful occupation. For the purpose of this rule and OAR 436-030-0065:

(a) "**Incapacitated from regularly performing work**" means that the worker does not have the necessary physical and mental capacity and the work skills to perform the essential functions of the job. Employment in a sheltered workshop is not considered regular employment unless this was the worker's job at the time of injury.

(b) "**Suitable occupation**" means those occupations that exist in a theoretically normal labor market, within a reasonable geographic distance, for which a worker has the

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training or experience, and abilities to realistically perform the job duties, with or without rehabilitation.

(c) "**Gainful occupation**" means those types of general occupations that provide wages that:

(A) Meet the requirements in ORS 656.206(11)(a) for workers with a date of injury prior to January 1, 2006; or

(B) Meet the requirements in ORS 656.206(11)(b) for workers with a date of injury on or after January 1, 2006.

(d) "**Work skills**" means those skills acquired through experience or training that are necessary to gain and adequately perform skilled, semi-skilled or unskilled occupations. Unskilled types of general occupations require no specific skills that would be acquired through experience or training to be able to gain and adequately perform the unskilled occupation. Every worker has the necessary work skills to gain and adequately perform unskilled types of general occupations with a reasonable period of orientation.

(e) A "**reasonable geographic distance**" means either of the following unless the worker is medically precluded from commuting:

(A) The area within a 50-mile radius of the worker's place of residence at the time of:

(i) The original injury;

(ii) The worker's last gainful employment;

(iii) Insurer's determination; or

(iv) Reconsideration by the director.

(B) The area in which a reasonable and prudent uninjured and unemployed person, possessing the same physical capacities, mental capacities, work skills, and financial obligations as the worker does at the time of the rating of disability, would go to seek work.

(f) "**Types of general occupations**" means groups of jobs which actually exist in a normal labor market, and share similar vocational purpose, skills, duties, physical circumstances, goals, and mental aptitudes. It does not refer to any specific job or place of employment for which a job or job opening may exist in the future.

(g) "**Normal labor market**" means a labor market that is undistorted by such factors as local business booms and slumps or extremes of the normal cycle of economic activity, or technology trends in the long-term labor market.

(h) "**Withdrawn from the workforce**" means a worker who is not employed, is not willing to be employed, or although willing to be employed is not making reasonable efforts to find employment, unless such efforts would be futile. The receipt of retirement benefits does not establish a worker has withdrawn from the workforce.

(2) All disability that existed before the injury must be included in determining permanent total disability.

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- (3) In order for a worker to be determined permanently and totally disabled, a worker must:
- (a) Prove permanent and total disability;
 - (b) Be willing to seek regular and gainful employment;
 - (c) Make reasonable effort to find work at a suitable and gainful occupation or actively participate in a vocational assistance program, unless medical or vocational findings, including the residuals of the compensable injury, make such efforts futile; and
 - (d) Not have withdrawn from the workforce during the period for which benefits are being sought.
- (4) A worker retaining some residual functional capacity and not medically permanently and totally disabled must prove:
- (a) The worker has not withdrawn from the workforce for the period for which benefits are being sought;
 - (b) Inability to regularly perform work at a gainful and suitable occupation; and
 - (c) The futility of seeking work if the worker has not made reasonable work search efforts by competent written vocational testimony. Competent written vocational testimony is that which is available at the time of closure or reconsideration and comes from the opinions of persons fully certified by the State of Oregon to render vocational services.
- (5) Notices of Closure and Orders on Reconsideration that grant permanent total disability must notify the worker that:
- (a) The claim must be reexamined by the insurer at least once every two years, and may be reviewed more often if the insurer chooses.
 - (b) The insurer may require the worker to provide a sworn statement of the worker's gross annual income for the preceding year. The worker must make the statement on a form provided by the insurer in accordance with the requirements under section (6) of this rule.
- (6) If asked to provide a statement under (5)(b) of this rule, the worker is allowed 30 days to respond. Such statements are subject to the following:
- (a) If the worker fails to provide the requested statement, the director may suspend the worker's permanent total disability benefits. Benefits must be resumed when the statement is provided. Benefits not paid for the period the statement was withheld must be recoverable for no more than one year from the date of suspension.
 - (b) If the worker provides a report that is false, incomplete, or inaccurate, the insurer must investigate. The investigation may result in suspension of permanent total disability benefits.

Statutory authority: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Statutes implemented: ORS 656.005, ORS 656.206, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, 1999 OR Laws Chapter 313, and chapter 865, Oregon Laws 2001
Hist: Amended 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

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Amended 6/13/22 as Admin. Order 22-056, eff. 7/1/22

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0065 Review of Permanent Total Disability Awards

(1) The insurer must reexamine each permanent total disability claim at least once every two years or when requested to do so by the director to determine if the worker has materially improved, either medically or vocationally, and is capable of regularly performing work at a suitable and gainful occupation. The insurer must notify the worker and the worker's attorney if the worker is represented whenever the insurer intends to reexamine the worker's permanent total disability status. Workers who fail to cooperate with the reexamination may have benefits suspended under OAR 436-060-0095.

(2) A worker receiving permanent total disability benefits must submit to a vocational evaluation, if requested by the director, insurer, or self-insured employer under ORS 656.206(8).

(3) Any decision by the insurer to reduce permanent total disability must be communicated in writing to the worker, and to the worker's attorney if the worker is represented, and accompanied by documentation supporting the insurer's decision. That documentation must include: medical reports, including sufficient information necessary to determine the extent of permanent partial disability, vocational and investigation reports (including visual records, if available) that demonstrate the worker's ability to regularly perform a suitable and gainful occupation, and all other applicable evidence.

(4) An award of permanent total disability for scheduled injuries before July 1, 1975, may be considered for reduction only when the insurer has evidence that the medical condition has improved.

(5) Except for section (4) of this rule, an award of permanent total disability may be reduced only when the insurer has a preponderance of evidence that the worker has materially improved, either medically or vocationally, and is regularly performing work at a suitable and gainful occupation or is currently capable of doing so. Preexisting disability must be included in redetermination of the worker's permanent total disability status.

(6) When the insurer reduces a permanent total disability claim, the insurer must, based upon sufficient information to determine the extent of permanent partial disability, issue a Notice of Closure, Permanent Total Disability Reduction ([Form 1644p](#)) that reduces the permanent total disability and awards permanent partial disability, if any.

(7) Notices of Closure reducing permanent total disability are appealable to the board.

(8) If a worker is receiving permanent total disability benefits and sustains a new compensable injury, the worker is eligible for additional benefits for the new compensable injury, except that the worker's eligibility for compensation for the new compensable injury is limited to medical benefits under ORS 656.245 and permanent partial disability benefits for impairment, as determined in the manner set forth in ORS 656.214(2).

Statutory authority: ORS 656.268, 656.726

Statutes implemented: ORS 656.206, 656.214, 656.268, 656.283, 656.319, 656.325, 656.331, 656.726

Hist: Amended 1/29/15 as Admin. Order 15-052, eff. 3/1/15

Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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

For claims having a date of injury prior to January 1, 2005, which involve unscheduled body parts, areas, or systems as defined by OAR 436-035-0005, and all claims with dates of injury on or after January 1, 2005, an award of permanent partial disability is subject to periodic examination and adjustment under ORS 656.268 and 656.325 and in accordance with the following conditions:

- (1) Requests for review and adjustment must be made in writing to the division.
- (2) The party requesting review of permanent disability must send a copy of the request to all involved parties at the time the request is made. The worker may submit any information in rebuttal.
- (3) All pertinent medical, vocational, and other applicable evidence must be submitted with the request, including sufficient information to determine the extent of permanent partial disability. The request must state the basis for the request and provide supporting evidence. If the director finds that the worker has failed to accept treatment as provided in this rule, the director will make any necessary adjustments allowed under OAR 436-035.
- (4) The basis for the request for adjustment in the permanent disability award must be asserted to be failure of the worker to make a reasonable effort to reduce the disability.

Statutory authority: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
 Statutes implemented: ORS 656.325, ORS 656.331, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
 Hist: Amended 10/26/04 as WCD Admin. Order 04-062, eff. 1/1/05
 Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
 See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0115 Reconsideration of Notices of Closure

- (1) A worker, insurer, or beneficiary may request reconsideration of a Notice of Closure as provided in ORS 656.268.
- (2) Under ORS 656.218(4), a worker's estate may request reconsideration of a Notice of Closure if the worker dies before filing a request and there are no persons entitled to receive death benefits under ORS 656.204.
- (3) A request for reconsideration may be made by mailing, phoning, or delivering the request to the director within the statutory appeal period as defined in OAR 436-030-0005 and 436-030-0145(1). The reconsideration proceeding begins as described in OAR 436-030-0145(2).
- (4) For the purpose of these rules, "reconsideration proceeding" means the procedure established to reconsider a Notice of Closure and does not include personal appearances by any of the parties to the claim or their representatives, unless requested by the director. All information to correct or clarify the record and any medical evidence regarding the worker's condition as of the time of claim closure that should have been but was not submitted by the attending physician or authorized nurse practitioner at the time of claim closure and all supporting documentation must be presented during the reconsideration proceeding. When the reconsideration proceeding is postponed under OAR 436-030-0165(9) because the worker's condition is not medically stationary, medical evidence submitted may address the

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worker's condition after claim closure as long as the evidence satisfies the conditions of OAR 436-030-0145(3).

(5) All parties have an opportunity to submit documents to the record regarding the worker's status at the time of claim closure. Other factual information and written argument may be submitted for incorporation into the record under ORS 656.268(6) within the time frames outlined in OAR 436-030-0145. Such information may include, but is not limited to, responses to the documentation and written arguments, written statements, and sworn affidavits from the parties.

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

(a) The deposition must be limited to the testimony and cross-examination of a worker about the worker's condition at the time of claim closure.

(b) The deposition must be arranged by the worker and held during the reconsideration proceeding time frame unless a good cause reason is established. If a good cause reason is established, the time frame for holding the deposition may be extended but may not extend beyond 30 days from the date of the Order on Reconsideration. The deposition must be held at a time and place that permits the insurer or self-insured employer the opportunity to cross-examine the worker.

(c) The insurer or self-insured employer must, within 30 days of receiving a bill for the deposition, pay the fee of the court reporter, the costs for the original transcript and one copy for each party, and the cost of necessary interpreter services. An original transcript of the deposition must be sent to the department and each party must be sent a copy of the transcript.

(d) If the transcript is not completed and presented to the department prior to the deadline for issuing an Order on Reconsideration, the Order on Reconsideration may not be postponed to receive a deposition under this rule and the order will be issued based on the evidence in the record. However, the transcript may be received as evidence at a hearing for an appeal of the Order on Reconsideration.

(7) Only one reconsideration proceeding may be completed on each Notice of Closure and the director will review those issues raised by the parties and the requirements under ORS 656.268(1). Once the reconsideration proceeding is initiated, issues must be raised and further evidence submitted within the time frames allowed for processing the reconsideration request. When the director requires additional information to complete the record, the reconsideration proceeding may be postponed under ORS 656.268(6).

Statutory authority: ORS 656.726

Statutes implemented: ORS 656.218, 656.268

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

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0125 Reconsideration Form and Format

A request for reconsideration may be in the form and format the director provides in [Bulletin 227](#). A reconsideration request should include at least the following:

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- (1) Worker's name;
- (2) Date of injury;
- (3) Date of the closure being appealed;
- (4) Any specific issues regarding the Notice of Closure;
- (5) The name of the worker's attorney, if any;
- (6) The name of the insurer's attorney, if any;
- (7) If the request is made by a beneficiary of the worker or the worker's estate, the identity and name of the requester, the name of the requester's attorney, if any, and contact information;
- (8) Any special language needs;
- (9) Whether there is disagreement with the specific impairment findings used to determine permanent disability at the time of claim closure;
- (10) Any information and documentation deemed necessary to correct or clarify any part of the claim record believed to be erroneous; and
- (11) Any medical evidence that should have been but was not submitted at the time of the claim closure including clarification or correction of the medical record based on the examination(s) at, before, or pertaining to claim closure.

Statutory authority: ORS 656.726

Statutes implemented: ORS 656.268

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

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0135 Reconsideration Procedure

(1) Within 14 days from the date of the director's notice of the start of the reconsideration proceeding, the insurer must provide, in chronological order by document date, all documents pertaining to the claim including, but not limited to, the complete medical record and all official action and notices on the claim, to:

- (a) The director;
 - (b) The worker or the worker's attorney;
 - (c) The beneficiary or beneficiary's attorney, if the request was made by the beneficiary;
- and
- (d) The estate or estate's attorney, if the request was made by the worker's estate.

(2) The request for reconsideration and all other information submitted to the director by any party during the reconsideration process must be copied to all interested parties. Failure to comply with this requirement may result in the information not being included as part of the record on reconsideration.

(3) The director may issue an order rescinding a Notice of Closure if any of the following apply:

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- (a) The claim was not closed as prescribed by rule.
 - (b) In a claim closed under ORS 656.268(1)(a), the worker was not medically stationary at the time of claim closure.
 - (c) In a claim closed under ORS 656.268(1)(a) or 656.268(1)(b), the claim was closed without sufficient information to determine the extent of permanent disability under OAR 436-030-0020(2).
 - (d) In a claim closed under ORS 656.268(1)(c), the claim was not closed in strict compliance with OAR 436-030-0034.
- (4) When a worker has requested and cashed a lump sum payment, under ORS 656.230, of an award granted by a Notice of Closure, the director will not consider the adequacy of that award in a reconsideration proceeding.
- (5) When a new condition is accepted after a prior claim closure, and the newly accepted condition is subsequently closed, the director and the parties may mutually agree to consolidate requests for review of the closures into one reconsideration proceeding, provided the director has jurisdiction and neither of the closures have become final by operation of law.
- (6) The reconsideration order may affirm, reduce, or increase the compensation awarded by the Notice of Closure.
- (7) After the reconsideration order has been issued and before the end of the 30-day appeal period for the order on reconsideration, if a party discovers that additional documents were not provided by the opposing party in accordance with this rule, the Order on Reconsideration may be abated and withdrawn to give the party an opportunity to respond to the new information.

Statutory authority: ORS 656.726

Statutes implemented: ORS 656.268 (2015 Or Laws, Ch. 144)

Hist: Amended 5/21/15 as Admin. Order 15-059, eff. 5/21/15 (Temp)

Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0145 Reconsideration Time Frames and Postponements

- (1) When appealing a Notice of Closure for claims that are medically stationary or that statutorily qualified for closure on or after June 7, 1995, a request for reconsideration must be mailed within:
- (a) Sixty (60) days of the mailing date of the Notice of Closure for a worker's request.
 - (b) Seven (7) days of the mailing date of the Notice of Closure for an insurer's request. An insurer's request for reconsideration is limited to the findings used to rate impairment.
 - (c) Sixty (60) days of the mailing date of the Notice of Closure for a beneficiary's request if the Notice of Closure was mailed to the beneficiary under ORS 656.268(5)(b).
 - (d) One year of the date the Notice of Closure was mailed to the estate of the worker if the Notice of Closure was not mailed to the beneficiary under ORS 656.268(5)(b).
- (2) The reconsideration proceeding begins upon:

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- (a) The director's receipt of the worker's, estate's, or beneficiary's request for reconsideration, if the insurer has not previously requested reconsideration consistent with (1)(b) of this rule; or
- (b) The 61st day after the closure of the claim, if the insurer has requested reconsideration consistent with (1)(b) of this rule, unless the director receives, within the appeal time frames in section (1) of this rule, a request for reconsideration or a statement by the worker, estate, beneficiary, or representative instructing the director to start the reconsideration proceeding.
- (3) Fourteen days from the date of the director's notice of the start of the reconsideration proceeding, the reconsideration request and all other appropriate information submitted by the parties will become part of the record used in the reconsideration proceeding. Requests for a medical arbiter panel must be submitted within this time frame.
- (a) Evidence received or issues raised subsequent to the 14-day deadline will be considered in the reconsideration proceeding to the extent practicable.
- (b) Upon review of the record the director may request, under ORS 656.268(6), any additional information deemed necessary for the reconsideration and set appropriate time frames for response.
- (c) Except as provided in sections (4), (5), and (6) of this rule, the director will, within 18 working days from the date the reconsideration proceeding begins, either mail an Order on Reconsideration or notify the parties that the reconsideration proceeding is postponed for not more than 60 additional days as provided under ORS 656.268(6).
- (4) The director may delay the reconsideration proceeding and toll the reconsideration timeline for up to 45 days when both parties provide written notice to the director requesting the delay for settlement negotiations. The notice is only effective if the director receives it before the 18th working day after the reconsideration proceeding begins.
- (a) This delay of the reconsideration proceeding expires:
- (A) When the director receives a written request from either party to resume the reconsideration proceeding;
- (B) When the director receives a copy of the approved settlement resolving some or all of the issues raised at the reconsideration proceeding; or
- (C) On the next calendar day following the authorized delay period.
- (b) The director may authorize only one delay period for each reconsideration proceeding.
- (5) When the director provides notice the worker failed to attend the medical arbiter examination without good cause or failed to cooperate with the arbiter examination and suspends benefits under ORS 656.268(8), the reconsideration proceeding will be postponed for up to 60 additional days from the date the director determines and provides notice, to allow completion of the arbiter process.
- (6) The reconsideration proceeding may be stayed under the following circumstances:

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(a) The parties consent to deferring the reconsideration proceeding, under ORS 656.268(8)(i)(B), when the medical arbiter examination is not medically appropriate because the worker's medical condition is not stationary; or

(b) When a claim disposition agreement (CDA) is filed. If this occurs, the reconsideration proceeding is stayed until the CDA is either approved or set aside.

(7) If the director fails to mail an Order on Reconsideration or a Notice of Postponement under the time frames specified in ORS 656.268, the reconsideration request is automatically deemed denied. The parties may immediately thereafter proceed as though the director had issued an Order on Reconsideration affirming the Notice of Closure.

(8) Notwithstanding any other provision regarding the reconsideration proceeding, the director may extend nonstatutory time frames to allow the parties sufficient time to present evidence and address their issues and concerns.

Statutory authority: ORS 656.726

Statutes implemented: ORS 656.268

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

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0155 Reconsideration Record

(1) The record for the reconsideration proceeding includes all documents and other material relied upon in issuing the Order on Reconsideration as well as any additional material submitted by the parties, but not considered in the reconsideration proceeding.

(a) The record is maintained by the division and consists of all documents and material documented as received by the director prior to the issuance of the Order on Reconsideration, unless the document is an exact duplicate of what is in the file then the director is not required to retain the duplicate document.

(b) The insurer or self-insured employer may not send billing information and duplicate documents to the department, unless specifically requested by the director.

(c) Evidence stored by the parties on audio media and submitted as part of the reconsideration record may only be submitted in transcribed form.

(2) Except as noted in this section, the medical record submitted by the director for arbiter review will consist of all medical documents and medical material produced by the claim under reconsideration, provided the information is allowable under ORS 656.268.

(3) The director will send non-medical information, nursing notes, or physical therapy treatment notes to the arbiter if:

(a) A party requests the director to submit those specific materials;

(b) The party identifies and provides the director with specific dates of those materials requested to be submitted; and

(c) The materials otherwise meet the requirements of this rule.

(4) When any surveillance video obtained prior to closure has been submitted to a physician involved in the evaluation or treatment of the worker, it must be provided for arbiter review.

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(a) Surveillance video provided for arbiter review must have been reviewed prior to claim closure by a physician involved in the evaluation or treatment of the worker.

(b) All written materials previously forwarded to a physician along with the surveillance video, such as investigator field notes, summary or narrative reports, and cover letters, must also be submitted.

(c) Surveillance video must be labeled according to the date and total time of the recording.

(5) When reconsideration is requested, the insurer is required to provide the director and the other parties with a copy of all documents contained in the record at claim closure. For cases involving a health care provider who must meet criteria other than those of an attending physician or who practices under contract with a managed care organization, the insurer must provide documentation of the health care provider's authority to act as an attending physician. Responses of the parties to the medical arbiter report will be included in the record if received prior to completion of the reconsideration proceeding.

Statutory authority: ORS 656.726

Statutes implemented: ORS 656.268

Hist: Amended 12/1/2009 as WCD Admin. Order 09-056 eff. 1/1/2010

Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0165 Medical Arbiter Examination Process

(1) The director will select a medical arbiter physician or a panel of physicians in accordance with ORS 656.268(8).

(a) For the purpose of this rule, a "panel" of physicians is defined as two or three medical arbiters.

(b) When a panel medical arbiter examination is requested, the director will generally appoint three medical arbiters. The director may consider the following criteria when determining whether to appoint two medical arbiters instead:

(A) The location of the worker;

(B) The specialties of the doctors needed for the medical arbiter examination; and

(C) The time frame for completing the reconsideration process.

(c) Any party that objects to a physician on the basis that the physician is not qualified under ORS 656.005(12)(b) must notify the director of the specific objection before the examination. If the director determines that the physician is not qualified to be a medical arbiter on the specific case, an examination will be scheduled with a different physician.

(d) When the worker resides outside the state of Oregon, a medical arbiter examination may be scheduled out-of-state with a physician who is licensed within that state to provide medical services in the same manner as required by ORS 656.268(8).

(e) Arbiters or panel members will not include any health care provider whose examination or treatment is the subject of the review.

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- (f) The insurer must pay all costs related to the completion of the medical arbiter process in this rule. These costs may include, but are not limited to, costs for child care, travel, meals, lodging, and an amount equivalent to the worker's net lost wages for the period during which it is necessary to be absent from work to attend the medical examination if the worker does not receive benefits under ORS 656.210(4) during the period of absence.
- (2) If the director determines there are enough appropriate physicians available to create a list of possible arbiters and it is practicable, each party will be given the opportunity to agree on a physician and to remove one physician from the list through the process described below:
- (a) The director will send the list to the parties electronically or by overnight mail.
 - (b) If the parties agree on a physician, every party must send a signed, written notice of that choice to the director.
 - (c) A party can remove a physician from the list, even when the parties have agreed on a physician to conduct the exam, by submitting a signed, written notice of that choice to the director.
 - (d) To be effective, the written notice of agreement on or rejection of a physician must be received by the director within three working days of the date the director sent the list.
- (3) The worker's disability benefits will be suspended when the director determines the worker failed to attend or cooperate with the medical arbiter examination, unless the worker establishes a "good cause" reason for missing the examination or for not cooperating with the arbiter. The worker must call the director within 24 hours of the missed examination to provide any "good cause" reason.
- (a) Notice of the examination will be considered adequate notice if the appointment letter is mailed to the last known address of the worker and to the worker's attorney, if the worker is represented.
 - (b) For the purposes of this rule, non-cooperation includes, but is not limited to, refusal to complete any reasonable action necessary to evaluate the worker's impairment. However, it does not include circumstances such as a worker's inability to carry out any part of the examination due to excessive pain or when the physician reports the findings as medically invalid.
 - (c) Failure of the worker to respond within the time frames outlined in statute for completion of the reconsideration proceeding may be considered a failure to establish "good cause."
- (4) If a worker misses the medical arbiter examination, the director will determine whether or not there was a "good cause" reason for missing the examination.
- (5) Upon determination that there was not a "good cause" reason for missing the examination, or that the worker failed to cooperate with the arbiter, the worker's disability benefits will be suspended and the reconsideration proceeding postponed for up to an additional 60 days.
- (6) The suspension will be lifted if any of the following occur during the additional 60-day postponement period:

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(a) The worker establishes a "good cause" reason for missing or failing to cooperate with the examination;

(b) The worker withdraws the request for reconsideration; or

(c) The worker attends and cooperates with a rescheduled arbiter examination.

(7) If none of the events that end the suspension under section (6) of this rule occur before the expiration of the 60-day additional postponement, the suspension of benefits will remain in effect.

(8) The medical arbiter or panel of medical arbiters must perform a record review or examine the worker as requested by the director and perform such tests as may be reasonable and necessary to establish the worker's impairment.

(a) The parties must submit to the director any issues they wish the medical arbiter or panel of medical arbiters to address within 14 days of the date of the director's notice of the start of the reconsideration proceeding. The parties may not submit issues directly to the medical arbiter or panel of medical arbiters. The medical arbiter or panel of medical arbiters will only consider issues appropriate to the reconsideration proceeding.

(b) The report of the medical arbiter or panel of medical arbiters must address all questions raised by the director.

(c) The medical arbiter will provide copies of the arbiter report to the director, the worker or the worker's attorney, and the insurer within five working days after completion of the arbiter review. The cost of providing copies of such additional reports must be reimbursed according to OAR 436-009-0060 and must be paid by the insurer.

(9) When a worker's medical condition prevents the worker from fully participating in a medical arbiter examination that must be conducted to determine findings of impairment, the director may send a letter to the parties requesting consent to defer the reconsideration proceeding. The medical condition that prevents the worker from participating in the medical arbiter examination does not need to be related to the work injury.

(a) If the parties agree to the deferral, the reconsideration proceeding will be deferred until the medical record reflects the worker's condition has stabilized sufficiently to allow for examination to obtain the impairment findings. The parties must notify the director when it is appropriate to schedule the medical arbiter examination and provide the necessary medical records when requested. Interim medical information that may be helpful to the director and the medical arbiter in assessing and describing the worker's impairment may be submitted at the time the parties notify the director that the medical arbiter examination can be scheduled. The director will determine whether the interim medical information is consistent with the provisions of ORS 656.268(6) and (8).

(b) If deferral is not appropriate, at the director's discretion either a medical arbiter examination or a medical arbiter record review may be obtained, or the director may issue an Order on Reconsideration based on the record available at claim closure and other evidence submitted in accordance with ORS 656.268(6).

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(10) All costs related to record review, examinations, tests, and reports of the medical arbiter must be billed and paid under OAR 436-009-0010, 436-009-0030, 436-009-0040, and 436-009-0060.

(11) When requested by the board, the director may schedule a medical arbiter examination for a worker who has appealed a Notice of Closure rescinding permanent total disability benefits under ORS 656.206.

Statutory authority: ORS 656.726

Statutes implemented: ORS 656.268 and ORS 656.325

Hist: Amended 10/10/17 as Admin. Order 17-058, eff. 1/1/18

Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0175 Fees and Penalties within the Reconsideration Proceeding

(1) An insurer failing to provide information or documentation as set forth in OAR 436-030-0135, 436-030-0145, 436-030-0155 and 436-030-0165 may be assessed civil penalties under OAR 436-030-0580. Failure to comply with the requirements set forth in OAR 436-030-0135, 436-030-0145, 436-030-0155, and 436-030-0165 may also be grounds for extending the reconsideration proceeding under ORS 656.268(6).

(2) If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer will be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent disability compensation. Penalties will not be assessed if an increase in compensation results from one of the following:

(a) An order issued by the director that addresses the extent of the worker's permanent disability that is not based on the standards adopted under ORS 656.726(4)(f);

(b) New information is obtained through a medical arbiter examination, for claims with medically stationary dates or statutory closure dates on or after June 7, 1995; or

(c) Information that the insurer or self-insured employer demonstrates they could not reasonably have known at the time of claim closure.

(3) For the purpose of section (2) of this rule, a worker who receives a total sum of 64 degrees of scheduled or unscheduled disability or a combination thereof, will be found to be at least 20 percent disabled.

For example: A worker who receives 20 percent disability of a great toe (3.6 degrees) is not considered 20 percent permanently disabled because the great toe is only a portion of the whole person. A worker who is 100 percent permanently disabled is entitled to 320 degrees of disability. A worker who receives 64 degrees (20 percent of 320 degrees), whether scheduled, unscheduled or a combination thereof, will be considered the equivalent of at least 20 percent permanently disabled for the purposes of this rule.

(4) Attorney fees under ORS 656.268(6)(c) are addressed in OAR 436-001-0432. Attorney fees under ORS 656.383(1) are addressed in OAR 436-001-0438.

Statutory authority: ORS 656.726

Statutes implemented: ORS 656.268, 656.383, 656.745

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Hist: Amended 11/1/07 as WCD Admin. Order 07-059, eff. 1/2/08
Amended 7/5/22 as WCD Admin. Order 22-062, eff. 9/1/22
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0185 Reconsideration: Settlements and Withdrawals

(1) Contested matters arising out of a claim closure may be resolved by mutual agreement of the parties at any time after the claim has been closed under ORS 656.268 but before that claim closure has become final by operation of law. If the parties have reached such an agreement prior to the completion of the reconsideration proceeding, the parties must submit the stipulation agreement to the director for approval as part of the reconsideration proceeding. The stipulation submitted for review at the reconsideration proceeding must:

(a) Address only issues that pertain to a claim closure and cannot include any issues of compensability; and

(b) List the body part for which any award is made and recite all disability awarded in both degrees and percent of loss as appropriate based on date of injury when permanent partial disability is part of the stipulated agreement. In the event there is any inconsistency between the stated degrees and percent of loss awarded in any stipulated agreement for claims with dates of injury prior to January 1, 2005, the stated percent of loss will control.

(2) The director will review the stipulation and issue an order approving or denying the stipulation. Stipulations approved by the director cannot be appealed.

(3) When the stipulated agreement does not expressly resolve all issues relating to the claim closure, the Order on Reconsideration will include the stipulation, as well as a substantive determination of all remaining issues. In these claims, the 18 working day time frame may be postponed in the same manner as any reconsideration proceeding.

(4) If the stipulation is not approved, the reconsideration proceeding will be postponed to allow the parties to:

(a) Address the disapproval, or

(b) Request that the director issue an Order on Reconsideration addressing the substantive issues.

(5) When the parties desire to enter into a stipulated agreement to resolve disputed issues relating to the claim closure, but are unable to reach an agreement, the parties may request the assistance of the director to mediate an agreement.

(6) When the parties desire to enter into a stipulated agreement that addresses all matters being reconsidered as well as issues not before the reconsideration proceeding, and the parties do not want a reconsideration on the merits of the claim closure, they may advise the director of their resolution and request the director enter an Order on Reconsideration affirming the Notice of Closure. The request for an affirming order must be made prior to the date an Order on Reconsideration is issued and in accordance with the following procedure.

(a) A written request for an affirming reconsideration order must:

(A) Be made by certified mail;

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- (B) Be signed by both parties or their representatives;
 - (C) State that the parties waive their right to an arbiter review and that all matters subject to the mandatory reconsideration process have been resolved; and
 - (D) Be accompanied by a copy of the proposed stipulated agreement.
- (b) After the affirming Order on Reconsideration has been issued, the parties will submit their stipulation to an administrative law judge of the board for approval in accordance with ORS 656.289 and the board's rules.
- (c) An Order on Reconsideration issued under this rule is final and is subject to review under ORS 656.283.
- (d) This provision does not apply to claims disposition agreements filed under ORS 656.236.
- (7) A worker requesting a reconsideration may withdraw the request for reconsideration without agreement of the other parties only if:
- (a) No additional information has been submitted by the other parties;
 - (b) No medical arbiter examination has occurred, and
 - (c) The insurer has not requested reconsideration under OAR 436-030-0145.
- (8) Notwithstanding (7) above, if additional information has been submitted by the other party(ies), a medical arbiter examination has occurred, or the insurer has requested reconsideration, the reconsideration request will not be dismissed unless all parties agree to the withdrawal.
- (9) If the insurer has requested reconsideration, either the worker or the insurer may initiate the withdrawal request, but both must agree to the withdrawal.

Statutory authority: ORS 656.726

Statutes implemented: ORS 656.268

Hist: Amended 11/1/07 as WCD Admin. Order 07-059, eff. 1/2/08

Amended 12/1/2009 as WCD Admin. Order 09-056 eff. 1/1/2010

Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0575 Audits

- (1) Notices of Closure and supporting documentation including, but not limited to, the Notice of Closure Worksheet ([Form 2807](#)) upon which the Notice of Closure is based, will be subject to periodic audit by the director. Supporting documentation and records must be maintained in accordance with OAR 436-050.
- (2) The insurer or self-insured employer is required to provide the director, within seven days of the director's request, any data the director identifies as necessary to determine the impact of legislative changes on permanent partial disability awards.

Statutory authority: ORS 656.268 and ORS 656.726

Statutes implemented: ORS 656.268, ORS 656.455, ORS 656.726, and ORS 656.750

Hist: Amended 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06

Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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436-030-0580 Penalties and Sanctions

- (1) Under ORS 656.745, the director or designee may assess a civil penalty against an employer or insurer who fails to comply with the statutes, rules, or orders of the director regarding reports or other requirements necessary to carry out the purposes of the Workers' Compensation Law.
- (2) An insurer or health care provider failing to meet the requirements set forth in these rules may be assessed a civil penalty.
- (3) Under OAR 436-010-0340, the director may impose sanctions for any health care provider where the insurer can provide sufficient documentation to substantiate lack of cooperation. The medical service provider will be sent a warning letter about the reporting requirements and possible penalties. Failure by the health care provider to submit the requested information within the specified period may result in civil penalties.
- (4) Sufficient documentation to substantiate lack of cooperation by the health care provider includes:
- (a) Copies of letters to the health care provider;
 - (b) Memos to the claim file of follow-up phone calls or the lack of response;
 - (c) Letters from the health care provider indicating a lack of cooperation; or
 - (d) Medical reports received by the insurer, after adequate instruction by the insurer or the director, which do not supply the requested information or which supply information that is not consistent with the Disability Rating Standards in OAR 436-035.

Statutory authority: ORS 656.268, 656.726

Statutes implemented: ORS 656.268, 656.726, 656.745

Hist: Amended 12/5/05 as WCD Admin. Order 105-073 eff. 1/1/07

Amended 12/1/2009 as WCD Admin. Order 09-056 eff. 1/1/2010

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.