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OREGON DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 30

CLAIMS EVALUATION AND DETERMINATION

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DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
CLAIMS EVALUATION AND DETERMINATION

EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 30

436-30-001 Authority for Rules

These rules are promulgated under the Director's authority contained in ORS 656.726(3) and ORS 656.268.

History: Filed 2/6/75 as WCB Admin. Order 5-1975, effective 2/26/75
Amended 6/30/78 as WCD Admin. Order 8-1978, effective 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Renumbered from OAR 436-65-000, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88
Amended 6/18/90 as WCD Admin. Order 7-1990, effective 7/1/90 (temp)

436-30-002 Purpose of Rules

These rules [provide uniform guidelines for disability evaluation under the Workers' Compensation Act,] describe the functions of Evaluation and prescribe the claim closure process.

History: Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Renumbered from OAR 436-65-002, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88
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436-30-003 Applicability of Rules

(1) **Except as provided in section (4) of this rule,** these rules are effective [January 1, 1988] **July 1, 1990** and apply to all accepted claims for workers' compensation benefits.

(2) All orders or requests issued by Evaluation **or the Appellate Unit** are considered an "order or request of the director."

(3) These rules take the place of the rules adopted on [January 1, 1982] **December 15, 1987** by Workers' Compensation Department Administrative Order [5]**13**, [1981] **1987**, and carry out the provisions of ORS 656.726(3)[.], [(a) ORS] 656.206[;]**,** [(b) ORS] 656.214[;]**,** [(c) ORS] 656.268[;]**,** [and] [(d) ORS] 656.325[;]**, 656.262, and Section 48 of chapter 2 Oregon Laws 1990, Special Session.**

(4) The provisions of OAR 436-30-009, 30-020, 30-030, and 30-050 apply to all claims which become medically stationary after July 1, 1990; for claims which become medically stationary prior to July 2, 1990 the provisions of OAR 436-30-020, 30-030, 30-050 as contained in WCD Administrative Order 13-1987 shall apply.

History: Filed 6/30/78 as WCD Admin. Order 8-1978, effective 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Renumbered from OAR 436-65-000, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88
Amended 6/18/90 as WCD Admin. Order 7-1990, effective 7/1/90, (temp)

436-30-005 Definitions

Except where the context requires otherwise, the construction of these rules is governed by the definitions given in the Workers' Compensation Law and as follows:

(1) "Appellate Unit" means the Appellate Unit of the Evaluation Section of the Workers' Compensation Division of the Department of Insurance and Finance.

[(1) "Board" means the Workers' Compensation Board of the Department of Insurance and Finance.]

[(2) "Combine" means to find a value for any two numbers, A and B, by using the formula: A + B(1.00-A), where A and B are written as decimals.]

(2) [(3)] "Department" means the Department of Insurance and Finance.

(3) [(4)] "Determination" means the review by Evaluation which establishes the extent of temporary or permanent disability to which a worker is entitled as a result of a compensable disabling injury.

(4) [(5)] "Director" means the Director of the Department of Insurance and Finance or the Director's delegate for the matter.

(5) [(6)] "Evaluation" means the Evaluation Section of the Workers' Compensation Division of the Department of Insurance and Finance.

(6) [(7)] "Insurer" means the State Accident Insurance Fund, or an insurer authorized under ORS chapter 731 to transact worker's compensation insurance in Oregon, a self-insured employer or a self-insured employer group.

(7) [(8)] "Medically stationary" means that no further material improvement in a worker's condition would reasonably be expected from treatment, or the passage of time.

(8) "Medical Arbiter" means a physician who is an attending physician pursuant to 656.005 12(b)(A) selected by the director pursuant to OAR 436 Division 10; after consultation with the Board of Medical Examiners for the State of Oregon and consultation with the labor/management advisory committee by the department.

(9) "Notice of Closure" means a notice to the worker issued by the insurer to close an accepted disabling claim provided by ORS 656.268(4).

(10) "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer.

(11) "Reconsideration" means a review proceeding by the Appellate unit when a party is dissatisfied with a Notice of Closure or Determination Order.

(12) "Worksheet" means a summary of facts used to derive the awards stated in the Notice of Closure or Determination Order.

[(9) "Return to Work" means that a worker has been hired in a permanent job (defined as permanent employment in OAR 436-110-005(6)(b)) and has demonstrated the physical capacity to perform that job.]

[(10) "Scheduled disability" means disability which results from injuries to those body areas listed in ORS 656.214(2)(a) through (4).]

[(11) "Unscheduled disability" means disability arising from those losses contemplated by ORS 656.214(5) and not to body parts or functions listed in ORS 656.214(2)(a) through (4).]

History: Filed 6/30/78 as WCD Admin. Order 8-1978, effective 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
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Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88
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436-30-008 Administrative Review

(1) Evaluation **and the Appellate Unit** may change or cancel any order it issues if it has made a[n] **technical** error [or if additional information is provided] which affects the order. Evaluation will act within 180 days after the order being changed or cancelled is mailed [only if a hearing has not been requested]. **The Appellate Unit will act within 180 days after the order being changed or cancelled is mailed only if a hearing has not been requested.**

(2) Any party to a claim who does not agree with an order of Evaluation may, within 180 days **of the mailing date of the Determination Order**:

(a) Request a**n administrative** review **of any technical error** [of that] **in a** determination order, by writing to the Evaluation Section, Workers' Compensation Division, Department of Insurance and Finance, Room 230, Labor and Industries Building, Salem, OR 97310**.** [, or by calling 378-3306]; or

(b) Ask Evaluation for a reconsideration **of the order, pursuant to OAR 436-30-009 and as provided in OAR 436-30-050;**[or

(c) Request a hearing on the claim by writing to the Hearings Division of the Workers' Compensation Board.]

(3) For the purpose of this rule, a technical "error" would include but not be limited to:

(a) Typographical errors.

(b) An error in the aggravation date.

(4) For any other matter in which a worker's right to compensation or the amount thereof is directly in issue, any party as defined in ORS 656.005(20), including SAIF Corporation as a designated processing agent pursuant to ORS 656.054, aggrieved by an action taken pursuant to these rules, may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS chapter 656 and the Board's Rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law.

(5) Any party aggrieved by an action taken pursuant to these rules involving any matter other than those described in sections (1-3), may request an informal administrative review. The process for administrative review shall be as follows:

(a) The request for administrative review shall be made in writing to the administrator of the Workers' Compensation Division within thirty (30) days of the action.

(b) The review shall be conducted by the administrator, or the administrator's designee. The administrator's decision on review will establish whether the decision is final or whether the aggrieved party may request a hearing before the director pursuant to 183.310.

(c) Any request for a hearing before the director pursuant to section (2), regarding the administrator's decision, must be made within 21 days of the date of the decision or the decision becomes final.

(6) When the issue which caused the action or decision qualifies for a hearing before

the director as a contested case, it shall be reviewed pursuant to ORS 183.310 to 183.550, as modified by these rules pursuant to ORS 183.315(1). When the issue qualifies as a contested case, the process for review will be as follows:

(a) The request for hearing shall be sent to the administrator of the Workers' Compensation Division. No hearing shall be granted unless the request specifies the grounds and is received by the division within thirty (30) days of the action or from the date of mailing or other service of an order.

(b) The hearing shall be conducted by the director or the director's designee.

(c) Any order in a contested case issued by another person on behalf of the director is a proposed order subject to revision by the director. The director may allow objections to the proposed order to be filed for the director's consideration within thirty (30) days of issuance of the proposed order.

History: Filed 06/30/78 as WCD Admin. Order 8-1978, effective 07/10/78
Amended 03/20/80 as WCD Admin. Order 4-1980, effective 04/01/80
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Amended 6/18/90 as WCD Admin. Order 7-1990, effective 7/1/90, (temp)

436-30-009 Appeals of Notice of Closures or Determination Orders or Notice of Refusal to Close

(1) [(3)] If the worker disagrees with the Notice of Closure **or a Determination Order** the worker **must first request a reconsideration by the Appellate Unit.** [may request: a redetermination by, and a personal interview with Evaluation.]

(2) If the worker disagrees with the Notice of Refusal to close, the worker may request redetermination by Evaluation.

(a) The request shall be [made] in writing.

(b) The request must be [made] **received by the department** within 180 days from the date of the Notice of Closure or determination order and 60 days from the date of [the] **a** notice of refusal to close.

(3) The reconsideration request must be made pursuant to OAR 436-30-050.

Stat. Auth: ORS Chapter 656
History: Renumbered from OAR 436-030-0020(3) as WCD Admin. Order 7-1990 (Temp), f. 6-18-90, eff. 7-1-90

436-30-010 Evaluation Responsibility

(1) Evaluation, when requested by a party to a claim, is responsible for, but not limited to:

(a) Determining the extent of permanent disability;

(b) **Determining the extent of temporary disability benefits;** [Authorizing termination of temporary disability benefits]

(c) [Establishing] **Determining** permanent total disability;

[(d) Reviewing Notice of Closures;]

[(e) [Reconsidering Determination Orders;]

(d) [(g)] **Determining medically stationary and non-stationary dates** [Establishing medically stationary dates]

(e) [(f)] **Determining the Disabling/Non-Disabling status of a claim;** [Deciding if claims are non-disabling; and]

(f) Reviewing permanent total disability awards.

(g) Reviewing permanent disability awards pursuant to ORS 656.325(3).

(h) Granting/approving offsets of overpayments pursuant to ORS 656.268(13)

(2) The Appellate Unit, when requested by a party to a claim is responsible for, but not limited to:

(a) Reconsideration of Notice of Closures;

(b) Reconsideration of Determination Orders.

History: Filed 2/6/75 as WCB Admin. Order 5-1975, effective 2/26/75
Amended 6/30/78 as WCD Admin. Order 8-1978, effective 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Amended 12/30/81 as WCD Admin. Order 5-1981, effective 1/1/82
Renumbered from OAR 436-65-004, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88
Amended 6/18/90 as WCD Admin. Order 7-1990, effective 7/1/90, (temp)

436-30-020 Insurer Claim Closure

(1) The insurer may issue a notice of closure on a**n accepted** disabling claim when medical information indicates the worker is medically stationary, and the worker has returned to [work] **regular or modified work, or the attending physician has released the worker to return to regular or modified work**.

(2) [(a)] When the insurer [elects to] close**s** the claim, [the insurer] **it** shall issue a Notice of [Claim] Closure to the worker within [14 calendar] **10** days after evidence is received which shows the **worker's** condition [to be] **is** medically stationary**,** and [sufficient] medical information is [available] **sufficient** to determine the extent of disability. **When making a determination of disability, the insurer shall:**

(a) Apply OAR 436-30-035 and OAR 436-30-036 regarding temporary disability determination and medically stationary status as prescribed by the department.

(b) Prepare a summary worksheet.

(3) For the purposes of section (2) of this rule, medical information is sufficient if it includes the information required in OAR 436-30-030(4)(5)(6).

(4) If the worker's condition became stationary on or after January 1, 1988, the insurer may determine the extent of permanent disability. The insurer shall apply the [same] standards **developed** for the rating of permanent disability [as those used by [Evaluation] **pursuant to ORS 656.726(3)**.

(5) [(b)] The [original] Notice of Closure shall be effective the date mailed. **The notice shall be in the form and format that director shall describe by bulletin. The notice shall include**

but not be limited to:

(a) The [amount] **dollar value** of any permanent disability **based on the value for the degree at the time the injury occurred;**

(b) The body part(s) – awarded disability, coded to the table of body part codes, (Appendix A), the percentage of loss, and the number of degrees that loss represents;

(c) The [amount and] **type and** duration of temporary disability compensation;

(d) The medically stationary date;

[The right of the worker to request a redetermination by, and a personal interview with, Evaluation within 180 days after the Notice of Closure is mailed; the right of the worker to request a hearing within 180 days after the notice, and,]

(e) The worker's aggravation rights; and

(f) The worker's appeal rights; and

(g) The right of the worker to consult with the ombudsman for injured workers.

(6) [(c)] The original **and three color coded copies of the** Notice of Closure [(white)] shall be mailed to**:** [the worker. A goldenrod copy shall be simultaneously mailed to the employer; a yellow copy shall be simultaneously mailed to the Department; and, a copy shall be simultaneously mailed to the worker's attorney pursuant to ORS 656.331(1)(b).]

(a) The worker (white copy);

(b) The employer (goldenrod copy);

(c) The department (yellow copy);

(d) The worker's attorney, if represented; and

(7) The insurer shall provide to the Department a copy of the worksheet upon which the Notice of Closure is based.

(8) The insurer shall provide the department a completed Form 2195 with any notice of closure awarding permanent disability.

(9) When a claim is closed by the insurer pursuant to ORS 656.268(2) the the same record shall be supplied to the worker or the worker's attorney, if requested.

[(9)] **(10)** A worker who has returned to work may request closure from the insurer. The insurer may:

(a) Request a Determination Order;

(b) Issue a Notice of Closure [if medically stationary]

(c) Issue a Notice of Refusal to Close

[(c) The request for a redetermination regarding the notice of closure or notice of refusal to close will not be acted on if made after a request for hearing is filed].

[(4) Regardless whether a request under section (2) has been made by the worker, Evaluation may change or cancel Notice of Closure within 180 days after the notice is mailed.]

[(5) If the worker disagrees with an insurer's Notice of Closure or Notice of Refusal to Close, the worker may request a hearing in

writing by delivering or mailing that request to the Hearings Division of the Workers Compensation Board. Within 180 days after the Notice of Closure is mailed or 60 days after the Notice of Refusal to Close.]

[(6) Nothing in these rules prevent the insurer from paying, voluntarily or otherwise, amounts in excess of the compensation required to be paid to the injured worker or beneficiaries under ORS 656.001 to 656.794. However, such payments must be clearly identified as payments made under ORS 656.018, and not compensation required by the Workers' Compensation Law.]

[(6)] **(11)** [Nothing in] These rules [shall] **do not** prohibit an insurer from rescinding or correcting its Notice of Closure **or Notice of Refusal to Close** prior to the time a request for **reconsideration** is [filed with Evaluation or a request for hearing is filed with the Board] **received by the department**.

[(8) Upon returned to work, if a Notice of Closure has not been previously issued, the worker may request claim closure by writing to the insurer. Within 10 working days of receiving the worker's written request, the insurer shall either close the claim, if medically stationary, request a determination from Evaluation, or issue a Notice of Refusal to Close. A Notice of Refusal to Close shall advise the worker of the decision on to close, of the right of the worker to request a hearing within 60 days of the notice, of the right to be represented by an attorney, and of the right to request a redetermination by Evaluation within 60 days of the notice.]

History: Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
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Amended 6/18/90 as WCD Admin. Order 7-1990, effective 7/1/90, (temp)

436-30-030 Evaluation Determination: Procedure

(1) Requests by the insurer for determination by Evaluation shall be [in the form and format] **as** prescribed by the Director.

(2) The worker or representative may write to Evaluation and request determination. If the worker has returned to work **or has been released to work**, Evaluation will notify the insurer of the worker's request so the insurer may choose whether to close the claim pursuant to OAR 436-30-020. If the insurer does not state that it will proceed to close the claim, Evaluation will act on the request for determination. The insurer shall submit all records to Evaluation within [14 calendar] **10** days after being notified of the worker's request.

(3) Unless the worker is actively engaged in training, the insurer shall request determination for those claims it elects not to close[: (a)] within [14 calendar] **10** days after the worker becomes medically stationary and sufficient medical information is available to determine the extent of disability;

[(b) After the 60th day following Department approval to suspend compensation benefits;]

[(c) After reasonable attempts to locate the worker have proven unsuccessful; or]

[(d) After the worker elects not to have further necessary treatment and there is little likelihood of the worker's condition improving with the passage of time.]

(4) The insurer shall notify the worker and the worker's attorney pursuant to ORS 656.331(1)(b), when a request for determination is made.

(5) When requesting a claim determination the insurer shall **submit completed Department Forms 1503 and 2195 and** provide to Evaluation**:**

(a) [any] **Copies of all** medical reports;

(b) A closing examination report which shall describe in detail all permanent

impairment due in the accepted claim;

(c) The dates of medically verified time loss including dates of modified work. Any reasons for broken periods of time loss shall also be explained or documented.

(6) In claims involving unscheduled permanent impairment the insurer shall provide the worker's work history, education and training to include:

(a) The highest school grade level completed.

(b) The date of any special training received.

(c) A description of professional certificates or licenses the worker holds.

(d) The work history by Dictionary of Occupational Titles or job description for the 10 years preceding the determination request, including dates or period of time spent at each position.

(e) The injured worker's current employment status. If working, also include the appropriate Dictionary of Occupational Title code for the job.

(f) All other records pertinent to claim determination.

[work histories, vocational reports, and agency reports about the worker and their injury which have not been provided to the Department.]

(7) When requesting claim determination pursuant to ORS 656.268(2) the same records shall be supplied to the worker or the worker's attorney **and the employer**, if requested.[The following conditions govern requests for determination:]

(8) Evaluation may require the insurer to provide additional information within 50 days of being requested as follows:

[(a) Evaluation may require the insurer to provide [specific] information held by the employer, the worker, any health care provider, or others involved in returning the worker to work. The insurer must provide such information to Evaluation within 60 days of the request, or the request for determination shall be invalid. Civil penalties may be imposed as provided in OAR 436.30580]

(a) Medical or other information from the attending physician or a report of a consultation or an independent medical examination.

[(b) Evaluation may order additional medical examinations, or studies to determine work potential.]

(b) Clarification of the worker's work/physical capacities.

[(c) Evaluation may conduct a personal interview with the worker.]

(9) Evaluation shall notify the insurer, worker and worker's representative within 10 working days if determination is premature because:

(a) The worker is not medically stationary.

(b) The worker is enrolled in a department approved training program.

(10) [(11)] When requested by the insurer, [Evaluation] **the department** shall declare the date on which the worker became medically stationary if the worker was in training pursuant to OAR 436-120, and the worker's date of injury was after December 31, 1973. This date will control

administrative fund reimbursements to insurers by the Department for injuries prior to January 1, 1986.

(11) [(6)] **Upon receipt of a Request for Determination** Evaluation shall:

(a) Apply [guidelines and] standards developed pursuant to ORS 656.726(3) when evaluating the permanent disability of an injured worker; and

(b) Issue a determination order within 10 working days following receipt of the request for determination; or

(c) Postpone the determination **for not more than a total of 70 days from receipt of the request** to obtain additional information necessary to that determination and notify the worker and any representative of the worker within 10 days following receipt of the request; [or]

(d) If the worker is medically stationary, close the claim based on whatever information is available on the 70th day after the receipt of the request for claim closure.
OR

(e) Issue a notice that claim closure is premature

[(d) Deny determination and notify the worker and any representative of the worker within 10 working days following the receipt of the request], if the worker's condition has not become medically stationary.

(12) [(7)] The effective date of the determination order shall be the date it is mailed. The mailing date appears on the order under "Date of Determination".

(13) A Determination Order will be mailed to the insurer. Copies of the Determination Order will be mailed to the worker at the worker's last known address, the worker's representative, and the employer at injury.

(14) [(8)] Evaluation may allow adjustment of payments to the worker for the following purposes:

(a) **To** recover payments for permanent partial disability which were made [too early] **prematurely**;

(b) **To** recover overpayments for temporary disability; or

(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.

[(9) Evaluation may deny any request to recover if it finds the overpayment result from benefits paid during a training program not approved by the Department.]

(15) [(10)] Evaluation may only allow overpayments **made on this claim** to be deducted from compensation to which the worker is entitled but has not yet been paid.

(16) [(12)] If, after claim closure, a worker is in **a Department approved** [authorized] training program pursuant to OAR 436-120, [the] permanent disability shall be [redetermined] **reconsidered** pursuant to **ORS 656.268** [656.265(5)] when the worker [is no longer engaged in such] **has ended** training **and the worker's condition is medically stationary. The following conditions will govern reconsideration of permanent disability:**

(a) The insurer may issue a Notice of Closure if the worker has returned or is released to return to work.

(b) The insurer shall submit the claim to Evaluation for determination if the worker has not returned or been released to work or chooses not to close the claim [the insurer shall promptly request determination or issue a Notice of Closure when the worker's training ends,] if the worker's condition **remains** [is] medically stationary.

History: Filed 2/6/75 as WCB Admin. Order 5-1975, effective 2/26/75
Amended 6/30/78 as WCD Admin. Order 8-1978, effective 7/10/78
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Amended 12/30/81 as WCD Admin. Order 5-1981, effective 1/1/82
Renumbered from OAR 436-65-010, May 1985
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436-30-035 Determining Medically Stationary Status

(1) A worker's condition shall be determined to be medically stationary when the attending physician or a preponderance of medical opinion declares the worker either "medically stationary," "medically stable," or uses other language meaning the same thing.

(2) When there is a conflict in the medical opinions as to whether or not a worker is medically stationary, more weight shall be given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principals, 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 shall generally be given to the opinion of the attending physician. However, in cases where expert analysis is important, deference shall be given to the opinion of the physician with the greatest expertise in and understanding of the worker's condition.

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

(5) A concurrence with another physician's report is a concurrence in every particular, including the medically stationary impression, unless the concurring physician expressly states to the contrary.

(6) A worker is medically stationary on the date so specified by a physician. When a specific date is not indicated, a worker will be considered medically stationary on the date of the last examination.

(7) Notwithstanding section (1) of this rule, where applicable, a worker shall be determined to be medically stationary on the earliest of the following dates:

(a) If a worker's compensation is suspended by the Department on the 60th day after the suspension order is mailed;

(b) If the worker fails without good cause to attend a mandatory independent

medical examination or consultation scheduled to determine the worker's medically stationary status and/or extent of permanent impairment, on the date the independent medical examination or consultation was scheduled;

(c) If the worker has not sought medical care for a period in excess of 28 days, unless so instructed by the attending physician, on the date the worker last sought medical care.

Stat. Auth: ORS Chapter 656
History: Renumbered from OAR 436-30-030(3)(b)
Filed 6/18/90 as WCD Admin. Order 7-1990, effective 7/1/90, (temp)

436-30-036 Temporary Disability Determination Procedure

(1) Except as provided in section (3) of this rule, a worker is entitled to an award for temporary disability for all periods of time during an open claim in which the attending physician or nonattending physician has, pursuant to OAR 436-10-030, authorized temporary disability.

(2) A worker is not entitled to any award for temporary disability for the first three days of temporary disability unless the worker was temporarily totally disabled for at least 14 consecutive days or was hospitalized as an inpatient during the initial time loss period.

(3) A worker is not entitled to any award for temporary disability for any period of time in which:

(a) The worker is medically stationary;

(b) The worker has been released by the attending physician to return to regular work;

(c) The worker has returned to regular work;

(d) The worker's compensation is suspended by the department pursuant to OAR 436-60-085 through OAR 436-60-105;

(e) The worker is incarcerated pursuant to OAR 436-60-045;

(f) The worker has withdrawn from the workforce;

(g) The worker's attending physician has not authorized temporary disability.

(h) The worker is deceased.

(4) A worker is entitled to an award for temporary total disability if the worker is totally disabled from working.

(5) A worker is entitled to an award for temporary partial disability if a worker is released to some form of work, whether or not the worker has returned to any form of work.

(6) Notwithstanding section (1) of this rule, a worker is not entitled to temporary partial disability for any period of time as provided for in section (3) and when a worker has refused modified employment within the physician's restrictions.

(7) A worker who is in a department approved training program (ATP) is entitled to an award of temporary disability for the duration of the program. If, when the ATP ends,

the worker is not then medically stationary, the worker is entitled to an award of temporary disability for periods of time after the end of the ATP in which the attending physician has authorized temporary disability, except as provided in sections (3) and (5).

(8) Awards of temporary disability shall include the day the worker is first determined to be medically stationary unless the worker has returned or been released to regular work.

(9) For the purpose of determining the applicability of section (3)(f), a worker has withdrawn from the workforce when:

(a) The worker is receiving Social Security Retirement income and the worker has manifested the intention to fully retire;

(b) If, prior to reopening pursuant to ORS 656.273 or 656.278, the worker was not working and had not made reasonable efforts to obtain employment;

(c) A worker has declined to cooperate with Direct Employment vocational services;

(d) A worker has elected to return to school or college on a full or part time basis, unless the worker can establish a prior customary practice of working while attending school or college.

(10) Where a worker is not entitled to an award for temporary disability due to any of the reasons specified in subsection (3)(e) or (f), the award shall so specify the reason.

Stat. Auth: ORS Chapter 656
History: Filed 6/18/90 as WCD Admin. Order 7-1990, effective 7/1/90, (temp)

436-30-045 Disabling/Non-disabling Status Determination

(1) Upon receipt of a request to review the status of a non-disabling claim, Evaluation shall request all medical and vocational reports from the insurer's claim file.

(2) Information requested by Evaluation shall be submitted by the insurer within 14 days of the request.

(3) Upon receipt of the information in the claim file, Evaluation shall within 10 days issue an order.

(4) The following conditions shall govern the decision that a claim is disabling:

(a) A claim will be considered disabling if it has resulted in the payment of temporary disability or;

(b) If, when medically stationary, the worker will be entitled permanent partial disability applying the standards developed pursuant to 656.726(3).

Stat. Auth: ORS Chapter 656
History: Filed 6/18/90 as WCD Admin. Order 7-1990, effective 7/1/90 (temp)

436-30-050 Reconsideration of Determination[s] Orders or Notices of Closure

(1) A determination order **or notice of closure** shall be reconsidered **by the Appellate Unit** [if:] **upon receipt of a written request for reconsideration by** one of the parties, asks for reconsideration by writing to the department [and] providing [medical information which was not available at the

time the original determination was made; and] **the request is received within 180 days from the mailing date of the determination order or notice of closure.**

(2)[A request for a hearing has not been made; and] **For the purpose of this rule. "reconsideration proceeding" means the procedure established to reconsider a Notice of Closure or Determination Order and does not generally include personal appearances by any of the parties to the claim or their representatives, unless requested to do so by the department.**

(3) [The request is delivered or mailed within 180 days after the determination order is mailed; and] **A request for a hearing on a determination order or a notice of closure which has not undergone reconsideration pursuant to this rule will be considered a reconsideration request. The receipt date of the reconsideration request will be the date received by the Hearings Division.**

(4) [No lump sum payment of the permanent partial disability has been made.] **The time to complete the reconsideration proceeding pursuant to this rule shall not be included in the 180 days from the mailing date of the notice of closure or determination order to request a hearing.**

(5) **Unless additional information is required, a Reconsideration Order shall be issued within 15 days of receipt, by the Appellate Unit, of a completed request for reconsideration. If additional information is required, a Reconsideration Order shall be issued within 75 days of the date the request for reconsideration was received.**

(6) The director may by Bulletin prescribe the form and format of the "reconsideration request" that shall include, but not be limited to, the Worker's Name, Social Security Number, Date of Injury and WCD File Number. A "completed reconsideration request" shall, in addition, include:

(a) a statement in bold face print and capital letters, "RECONSIDERATION REQUEST";

(b) the date, type and specific reason(s) for objection to the determination order or notice of closure;

(c) any information and documentation deemed necessary to correct any part of the claim record the party believes to be erroneous; and/or

(d) any medical evidence that should have been but was not submitted by the attending physician at the time of the claim closure being reconsidered.

(7) An Insurer, and a worker represented by an attorney must submit a "completed reconsideration request", pursuant to Section (5) of this rule, and provide copies to the other interested parties when requesting reconsideration of a notice of closure or determination order. A worker who is not represented by an attorney will be contacted by the department in order to develop a "completed reconsideration request." The department shall notify the insurer upon receipt of such a request from a worker. The worker shall have 14 days to submit a completed reconsideration request after contact by the department.

(8) When the insurer is notified of a reconsideration request pursuant to Section (5) & (6), of this rule, the insurer shall submit a copy of the same records used to make the

determination pursuant to 656.268(2) within 14 days.

(9) When a basis for the Reconsideration Request is a disagreement with the findings of impairment used in the Notice of Closure and Determination Order, the Director shall refer the claim to a medical arbiter or panel of arbiters pursuant to ORS 656.268(7) and OAR 436-10-047.

(10) All other information in the claim file pursuant to Section (5) of this rule, and the medical arbiter's findings, if applicable, and the documents used to issue the previous Determination Order or Notice of Closure will be the record upon which the reconsideration will be made.

(11) If upon reconsideration of a Notice of Closure there is an increase in the amount of compensation to be paid for permanent disability of 25 percent or more, and the worker is found to be at least 20 percent permanently disabled, the insurer shall be ordered to pay the worker an additional 25 percent of the amount of all permanent disability compensation then due.

(12) For the purpose of Section (11) of this rule, permanent disability for a scheduled award will be determined by converting the scheduled impairment to whole man impairment per the American Medical Association Guides to the Evaluation of Permanent Impairment, 3rd Edition.

(13) When a request for reconsideration is submitted by an attorney representing a worker, the Reconsideration Order shall order the insurer or self-insured employer to pay the attorney, out of any additional compensation awarded, an amount equal to 10 percent of any additional compensation awarded.

(14) When a worker has requested and received a lump sum payment, pursuant to OAR 436-60-060, of an award granted by a Notice of Closure or Determination Order, the appellate unit shall not consider the adequacy of the award in a reconsideration proceeding.

(15) When the Appellate Unit determines it is necessary to promulgate an emergency rule(s) to account for and rate a worker's impairment not otherwise described in the Disability Rating Standards, the reconsideration proceedings shall be stayed for no more than 60 days to develop and issue the rule(s). In the event emergency rules are required, the department shall notify all affected parties within five working days of the need to defer action.

(16) When the Appellate Unit finds, upon reconsideration, that the claim was closed prematurely, the Appellate Unit shall issue an order rescinding the Notice of Closure or Determination Order and remand the claim back to the insurer for processing in accordance with ORS Chapter 656.

(17) Compensation reduced in a Reconsideration Order shall be "in lieu of" any compensation awarded by the Notice of Closure or Determination Order.

(18) Additional compensation awarded in a Reconsideration Order shall be "in addition to" any compensation awarded by the Notice of closure or Determination Order.

(19) Any compensation affirmed in a Reconsideration Order shall be so stated.

(20) A copy of the Reconsideration Order will be sent to the worker, insurer, and attorney if the worker is represented.

History: Filed 6/30/78 as WCD Admin. Order 8-1978, effective 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Renumbered from OAR 436-65-100, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88
Amended 6/18/90 as WCD Admin. Order 7-1990, effective 7/1/90, (temp)

436-30-055 Permanent Total Disability

(1) A worker is permanently and totally disabled if permanently incapacitated from regularly performing work in a suitable and gainful occupation. A suitable and gainful occupation is an occupation for which the worker has the necessary physical capacity and the ability, training, or experience to perform.

(2) Disability which existed before the injury shall be included in determining permanent total disability.

(3) In order for a worker to be determined permanently and totally disabled, a worker must:

(a) Prove permanent and total disability.

(b) Show a willingness to seek regular work at a suitable and gainful occupation and make reasonable efforts to find such work, or actively participate in a vocational assistance program, unless the medical condition makes such efforts futile.

(4) Every determination order which grants permanent total disability shall notify the worker that:

(a) The claim shall be reviewed 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 shall make the statement on a form provided by the insurer in accordance with the requirements under section (5) of this rule.

(5) If asked to provide a statement under (4)(b) 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 shall suspend the worker's permanent total disability benefits. Benefits may be resumed when the statement is provided. Benefits not paid for the period the report was withheld shall be recoverable for no more than one year from the date of suspension.

(b) If the worker provides a report which is false, incomplete or inaccurate, the insurer shall investigate. The investigation may result in suspension of permanent total disability benefits.

History: Filed 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88

436-30-065 Review of Permanent Total Disability Awards

(1) The insurer shall review each permanent total disability claim every two years or when requested to do so by the Director to see if the worker's medical or vocational status has changed. The insurer shall send the results of the review to the Department.

(2) An award of permanent total disability for scheduled injuries before July 1, 1975, shall be reviewed by Evaluation only when the insurer has evidence that the medical condition has changed for the better.

(3) An award of permanent total disability for scheduled injuries on or after July 1, 1975, or for unscheduled injuries, shall be reviewed by Evaluation only when the insurer has evidence that the worker is working at a regular, suitable, and gainful occupation or is capable of doing so.

(4) Any request from the insurer to Evaluation to reduce permanent total disability shall be accompanied by documentation to support the request. That documentation may include medical, vocational, or investigation reports (including visual records, if available) which demonstrate a change in the physical condition or in employability.

(5) Evaluation shall issue a determination order stating that: the permanent total disability award has been reduced when the evidence demonstrates that the worker is no longer permanently and totally disabled.

(6) The worker may request a hearing if the permanent total disability award is reduced.

(a) Requests for hearing must be made in writing to the Workers' Compensation Board.

(b) Requests for hearing must be made within 180 days after the mailing date of the order reducing the award.

History: Filed 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88

436-30-066 Review of Prior Unscheduled Permanent Partial Disability Awards

(1) An award for unscheduled permanent partial disability is subject to periodic examination and adjustment pursuant to 656.268 and 656.325 and in accordance with the following conditions.

(a) Requests for review and adjustment shall be made in writing to the Evaluation Section of the Workers' Compensation Division, 230 Labor & Industries Building, Salem, OR 97310.

(b) The party requesting review of permanent disability shall inform the affected parties at the same time of the request. The worker may submit any information in rebuttal.

(c) All pertinent medical/vocational records shall be submitted with the request.

(d) The basis for the request for adjustment in the disability award shall be stated in the request for adjustment.

(2) The Evaluation Section shall make any necessary adjustments pursuant to OAR 436-35-270 through 436-35-315.

(3) The Evaluation Section shall issue a Determination Order within 20 days of

receipt of a complete request, allowing 10 days for the worker to respond to the notice of a request for adjustment in permanent disability.

History: Filed 6/18/90 as WCD Admin. Order 7-1990, effective 7/1/90, (temp)

436-30-580 Penalties

If the insurer fails to provide information requested by Evaluation, or fails to provide information in a timely manner, a civil penalty, pursuant to ORS 656.745 may be assessed. This penalty may be as much as $2,000 for each violation or up to $10,000 in the aggregate for all violations in any three-month period. Each day the information is not provided timely shall be considered a separate violation. OAR 436-60-200 will be followed in establishing penalties.

History: Filed 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88