WCD Admin. Order No. 94-055

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

In the Matter of the Amendment of Oregon Administrative Rule (OAR) Chapter 436, Division 60, Claims Administration	))))	ORDER OF ADOPTION

The Director of the Department of Consumer and Business Services, pursuant to the general rulemaking authority under ORS 656.726(3), and in accordance with the procedure provided by ORS 183.335, amends OAR Chapter 436, Department of Consumer and Business Services, Division 60, Claims Administration.

On May 13, 1994, the Department of Consumer and Business Services filed Notice of Public Hearing with the Secretary of State to amend rules governing Claims Administration. The Statement of Need and Legal Authority and the Statement of Fiscal Impact were also filed with the Secretary of State.

Copies of the notice were mailed to interested persons in accordance with ORS 183.335(7) and OAR 436-01-000 and to those on the Division's distribution mailing list as their interest indicated. The notice was published in the June 1, 1994 Secretary of State's Administrative Rule Bulletin.

On June 16, and 21, 1994, public hearings were held as announced. In addition, the hearing record was held open for written testimony through 5:00 p.m. on August 10, 1994. A written summary of the testimony and agency responses thereto is contained in Exhibit "C." This summary, as well as principal documents relied upon, is on file and available for public inspection between the hours of 8:00 a.m. and 5:00 p.m., normal working days Monday through Friday, in the Administrator's Office, Worker's Compensation Division, Labor & Industries Bldg., Salem, Oregon 97310.

EXPLANATION

THE RULES HAVE BEEN AMENDED TO RESTRICT ACCESS TO DEPARTMENT OF CONSUMER AND BUSINESS SERVICES WORKERS' COMPENSATION CLAIM FILE RECORDS, EXTEND THE PERIOD OF TIME USED IN DETERMINING A WORKER'S AVERAGE WEEKLY WAGE FROM 26 WEEKS TO 52 WEEKS, CLARIFY THE PROCESS WHEN REQUESTING SUSPENSION OF COMPENSATION AND TO ESTABLISH A RULE TO ASSURE ADEQUATE CONSIDERATION IS GIVEN TO THE WORKER'S LOST EARNING POWER AT ANY KIND OF WORK WHEN CALCULATING TEMPORARY PARTIAL DISABILITY.

VERTICAL BARS IN THE RIGHT MARGINS INDICATE NEW LANGUAGE.

Having reviewed and considered the record of public hearing and being fully advised, I make the following findings:

a. The applicable rulemaking procedures have been followed.
b. The rules are within the Director's authority.
c. The rules being adopted are a reasonable administrative interpretation of the statutes and are required to carry out statutory responsibilities.

PURSUANT TO THE AMERICANS WITH DISABILITIES ACT GUIDELINES, ALTERNATE FORMAT COPIES OF THE RULES WILL BE MADE AVAILABLE TO QUALIFIED INDIVIDUALS UPON REQUEST TO THE DIVISION.

IT IS THEREFORE ORDERED:

(1) OAR Chapter 436, Division 60, Claims Administration, as set forth in Exhibit "A" attached hereto, is certified a true copy and hereby made part of this Order, and adopted effective August 28, 1994.

(2) A certified true copy of the Order of Adoption and these rules, with Exhibit "B" consisting of the Citation of Statutory Authority, Statement of Need, Documents Relied On and Fiscal Impact Statement, attached hereto and hereby made a part of this Order, be filed with the Secretary of State.

(3) A copy of the rules and attached Exhibit "B" be filed with the Legislative Counsel pursuant to the provisions of ORS 183.715 within ten days after filing with the Secretary of State.

Dated this 11 day of August 1994.

DEPARTMENT OF CONSUMER
AND BUSINESS SERVICES

Kerry Barnett, Director

Attachments

Distribution: B thru V;
X thru AA;

6060-WCDDRAFT/flr (60-WCDRULES)
(08-11-94)

EXHIBIT "A"

CHAPTER 436
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

DIVISION 60

CLAIMS ADMINISTRATION

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EXHIBIT "A"

CHAPTER 436

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

DIVISION 60

CLAIMS ADMINISTRATION

AUTHORITY FOR RULES

436-60-001 These rules are promulgated under the Director's authority contained in ORS 656.210(2), 656.236(1), 656.262(10), 656.264, 656.265(6), 656.325, 656.331 and 656.726(3).

Stat. Auth.: ORS 656.210(2), ORS 656.236(1), ORS 656.262(10), ORS 656.264, ORS 656.265(6), ORS 656.325, ORS 656.331 and ORS 656.726(3)
Hist: Filed 12/19/75 as WCB Admin. Order 18-1975, eff. 1/1/76
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-001, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90

PURPOSE

436-60-002 The purpose of these rules is to prescribe uniform standards by which insurers shall process workers' compensation claims pursuant to ORS 656.726(3); and, the terms and conditions under which insurers may enter into dispositions of compensable claims pursuant to ORS 656.236(1). The Director has charged the Workers' Compensation Division with the administration and enforcement of the applicable statute, these rules, and all bulletins pertaining to claims processing. Failure to process claims in accordance with these rules will subject insurers to civil penalty under ORS 656.745; to penalties payable to the claimant pursuant to ORS 656.262(10); and, to sanctions pursuant to ORS 656.447.

Stat. Auth.: ORS 656.236(1), ORS 656.262(10), ORS 656.447, ORS 656.726(3) and ORS 656.745
Hist: Filed 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-008, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 6/8/92 as WCD Admin. Order 12-1992, eff. 7/1/92

APPLICABILITY OF RULES

436-60-003 (1) These rules govern claims processing and carry out the provisions of:

(a) ORS 656.210. Temporary total disability;

(b) ORS 656.212. Temporary partial disability;

(c) ORS 656.230. Lump sum payments;

(d) ORS 656.236. Disposition of compensable claims;

(e) ORS 656.262. Responsibility for processing and payment of compensation, sight drafts, acceptance and denial and reporting of claims, and penalties for payment delays;

(f) ORS 656.264. Required reporting of information to the Department;

(g) ORS 656.265. Notices of accidents from workers;

(h) ORS 656.268. Insurer claim closures;

(i) ORS 656.307. Determination of responsibility for compensation payments;

(j) ORS 656.325. Required medical examinations, suspension of compensation, injurious practices, claimant's duty to reduce disability, and reduction of benefits for failure to participate in rehabilitation;

(k) ORS 656.331. Notice to worker's attorney; and,

(l) ORS 656.726(3). The Department's powers and duties generally.

(2) The provisions of WCD Administrative Order No. 94-050 apply to all payments where a period of eligibility for temporary partial disability begins on or after March 1, 1994. The provisions of WCD Administrative Order No. 94-055 apply to all payments where a period of eligibility for temporary partial disability begins on or after August 28, 1994.

Stat. Auth.: ORS 656.210, ORS 656.212, ORS 656.230, ORS 656.236, ORS 656.262, ORS 656.264, ORS 656.265, ORS 656.268, ORS 656.307, ORS 656.325, ORS 656.331, and ORS 656.726(3)
Hist: Filed 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Amended 4/4/84 as WCD Admin. Order 3-1984, eff. 4/4/84
Renumbered from 436-54-003, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 1/3/92 as WCD Admin. Order 1-1992, eff. 2/1/92
Amended 2/28/94 as WCD Admin. Order 94-050, eff. 3/1/94 (Temp)
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

DEFINITIONS

436-60-005 For the purpose of these rules unless the context requires otherwise:

(1) "Aggravation" means a medically verified worsening of a condition arising from an industrial injury to the worker since the last award or arrangement of compensation for that injury as defined in ORS 656.273. A claim for aggravation requires written verification from an attending physician of a worsened condition, supported by objective findings.

(2) "Attending Physician" means a doctor or physician as defined in ORS 656.005(12) who accepts primary responsibility for the treatment of a worker's compensable injury.

(3) "Board" means the Workers' Compensation Board of the Department of Consumer and Business Services.

(4) "Claim" means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge.

(5) "Department" means the Department of Consumer and Business Services.

(6) "Director" means the Director of the Department of Consumer and Business Services or the Director's delegate for the matter.

(7) "Disposition" or "claim disposition" means the written agreement as provided in ORS 656.236 executed by all parties in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794, except for medical services, in an accepted claim. The term "compromise and release" has the same meaning.

(8) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(9) "Employer" means a subject employer as defined in ORS 656.023.

(10) "Employment on call" means sporadic, unscheduled employment at the call of an employer without recourse if the worker is unavailable.

(11) "Employment through union hall" means workers who report primarily to union halls for job placement.

(12) "Health insurance," as defined under ORS 731.162, means all insurance against bodily injury, illness or disability, and the resultant expenses, except for workers' compensation coverage.

(13) "Inpatient" means admission to a hospital prior to and extending past midnight for treatment and lodging. The need for medical services such as Emergency Room, Observation Room or short stay surgical treatments are not considered "inpatient."

(14) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in Oregon; or, an employer or employer group which has been certified under ORS 656.430 that it meets the qualifications of a self-insured employer under ORS 656.407.

(15) "Lump sum" means the payment of all or any part of a permanent partial disability award in one payment.

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

(17) "Paying Agent" means the insurer responsible for paying compensation for a compensable injury.

(18) "Physical rehabilitation program" means any disability prevention services which include physical restoration.

(19) "Suspension of compensation" means:

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

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

Stat. Auth.: ORS 656.726(3)(a)
Hist: Filed 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-005, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 1/3/92 as WCD Admin. Order 1-1992, eff. 2/1/92
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

ADMINISTRATION OF RULES

436-60-006 Any orders issued by the Division in carrying out the Director's authority to enforce ORS Chapter 656 and these rules are considered orders of the Director.

Stat. Auth.: ORS 656.726(3)
Hist: Filed 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-010, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90

ADMINISTRATIVE REVIEW

436-60-008 (1) Any party as defined by 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 in which a worker's right to compensation or the amount thereof is directly in issue, may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS Chapter 656 and the Board's Rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law except where otherwise provided in ORS Chapter 656.

(2) Contested case hearings of Sanctions and Civil Penalties: Any party as described in section (1) aggrieved by a proposed order or proposed assessment of civil penalty of the Director or Division issued pursuant to ORS 656.254, 656.735, 656.745 or 656.750 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

(a) The request for hearing must be sent in writing to the Administrator of the Workers' Compensation Division. No hearing shall be granted unless the request specifies the grounds upon which the person requesting said hearing contests the proposed order or assessment.

(b) The request for hearing must be filed with the Administrator of the Workers' Compensation Division within twenty (20) days of receipt by the aggrieved person of notice of the proposed order or assessment. No hearing shall be granted unless the request is received by the Administrator within said twenty (20) days of receipt of notice.

(3) Contested cases before the Workers' Compensation Division's hearings officer: Any party as described in section (1) aggrieved by an action or order of the Director or Division pursuant to these rules, other than as described in section (2), where such action or order qualifies for review by hearing before the Director as a contested case, may request review pursuant to ORS 183.310 through 183.550 as modified by these rules pursuant to ORS 183.315(1). When the matter qualifies for review as a contested case, the process for review shall be as follows:

(a) The request for hearing must be sent in writing to the Administrator of the Workers' Compensation Division. No hearing shall be granted unless the request specifies the grounds upon which the action or order is contested and is received by the Administrator 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.

(4) Administrative review by the Director or designee: Any party described in section (1) aggrieved by an action taken pursuant to these rules by another person except as described in sections (1) through (3) above may request administrative review by the Division on behalf of the Director. The process for administrative review of such matters shall be as follows:

(a) The request for administrative review shall be made in writing to the Administrator of the Workers' Compensation Division within ninety (90) days of the action. No administrative review shall be granted unless the request specifies the grounds upon which the action is contested and is received by the Administrator within ninety (90) days of the contested action unless the Director or his designee determines that there was good cause for delay or that substantial injustice may otherwise result.

(b) The review, including whether the request is timely and appropriate, may be conducted by the Administrator, or the Administrator's designee, on behalf of the Director.

(c) In the course of said review, the person conducting the review may request or allow such input or information from the parties as he or she deems to be helpful.

(d) The determination by the person conducting the review will specify whether the determination constitutes a final order or whether an aggrieved party may request a contested case hearing before the Director pursuant to ORS 183.310.

(e) Any request for a contested case hearing before the Director regarding a review determination made pursuant to this section must comply with the procedures provided in section (3) above.

(5) Contested cases before the Hearings Division of the Workers' Compensation Board: A party may request a hearing before the Hearings Division of the Workers' Compensation Board on any action taken pursuant to these rules where a worker's right to compensation or the amount thereof is directly an issue in accordance with the provisions of ORS Chapter 656.

Stat. Auth.: ORS 656.704, ORS 656.726(3) and ORS 656.745
Hist: File 4/27/78 as WCD Admin. Order 6-19-78, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-998, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90

ACCESS TO DEPARTMENT OF CONSUMER AND BUSINESS SERVICES WORKERS' COMPENSATION CLAIM FILE RECORDS

436-60-009 (1) Pursuant to ORS 192.430 and OAR 440-05-015(1) the Director, as custodian of public records, promulgates this rule to protect the integrity of claim file records and prevent interference with the regular discharge of the Department's duties.

(2) The Department rules on Access of Public Records, Fees for Record Search and Copies of Public Records are found in OAR 440-05. Payment of fees for access to records shall be made in advance unless the Director determines otherwise. Workers and insurers of record, their legal representatives and third-party administrators shall receive a first copy of any document free. Additional copies shall be provided at the rates set forth in OAR 440-05.

(3) Any person has a right to inspect nonexempt public records. The statutory right to "inspect" encompasses a right to examine original records. It does not include a right to request blind searches for records not known to exist.

(4) Pursuant to ORS 192.502(18) workers' compensation claims records are exempt from public disclosure. Access to workers' compensation claims records will be granted at the sole discretion of the Director in accordance with this rule, under the following circumstances:

(a) When necessary for insurers, self-insured employers and third-party claims administrators and their legal representatives for the sole purpose of processing workers' compensation claims. A request by telephone or facsimile transmission will be accepted, but requires provision of the claimant's social security number and insurer claim number in addition to the information required in section (7).

(b) When necessary for the Director, other governmental agencies of this state or the United States to carry out their duties, functions or powers.

(c) When the disclosure is made in such a manner that the disclosed information cannot be used to identify any worker who is the subject of a claim. Such circumstances include when workers' compensation claims file information is required by a public or private research organization in order to contact injured workers in order to conduct its research. The Director may enter into such agreements with such institutions or persons as are necessary to secure the confidentiality of the disclosed records.

(d) When a worker or the worker's representative requests review of the workers' claim record.

(5) The Director may release workers' compensation claims records to persons other than those described in section (4) when the Director determines such release is in the public interest.

(a) For the purpose of these rules, a "public interest" exists when the conditions set forth in ORS 192.502(18) and subsections (4)(a) through (d) of this rule have been met. The determination whether the request to release workers' compensation claims records meets those conditions shall be at the sole discretion of the Director.

(b) The Director may enter into written agreements as necessary to ensure that the recipient of workers' compensation claims records under this section uses or provides the information to others only in accordance with these rules and the agreement with the Director. The Director may terminate such agreements at any time the Director determines that one or more of the conditions of the agreement have been violated.

(6) The Director may deny or revoke access to workers' compensation claims records at any time the Director determines such access is no longer in the public interest or is being used in a manner which violates these rules or any law of the State of Oregon or the United States.

(7) Requests to inspect or obtain copies of workers' compensation claim records shall be made in writing or in person and shall include:

(a) The name address and telephone number of the requester;

(b) A specific identification of the public record(s) required and the format in which they are required;

(c) The number of copies required;

(d) The account number of the requester, when applicable.

(8) Except as prescribed in subsections (4)(a) through (d), a person must submit to the Division a release signed by the claimant in order to inspect or obtain copies of workers' compensation claims records. The Director may refuse to honor any release which the Director determines is likely to result in disclosed records being used in a manner contrary to these rules. Upon request, the Director will review proposed release forms to determine whether the proposed release is consistent with the law and this rule.

(9) Notwithstanding section (8), attorneys representing clients in other than worker' compensation matters will be granted access to workers' compensation claims information by filing a written request as prescribed in section (7) and affirming that the information shall be used solely to represent their client(s) interests. Such requests shall be in the form required by section (7) of this rule. Use of the information for any other purpose shall result in immediate revocation of access.

Stat. Auth.: ORS 656.726(3)
Hist: Filed 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

REPORTING REQUIREMENTS

436-60-010 (1) A subject employer shall accept notice of a claim for workers' compensation benefits from an injured worker or the worker's representative. Employers, except self-insured employers, shall report the claim to their insurers no later than five days after notice or knowledge of any claim or accident which may result in a compensable injury.

(2) If an injured worker requires no medical treatment or only first aid without medical services and is otherwise not entitled to compensation, no notice need be given the insurer. The employer shall maintain records showing the name of the worker, the date, nature of the injury and treatment for one year. These records shall be open to inspection by the Director, or any party or its representative. If an employer subsequently learns that such an injury has resulted in medical services, disability or death, the date of that knowledge will be considered as the date on which the employer received notice or knowledge of the claim for the purposes of processing pursuant to ORS 656.262. For the purpose of this section, "medical services" means any medical treatment normally provided by a licensed person, regardless of who provides it, or where it is provided.

(3) The Director may assess a civil penalty against an employer delinquent in reporting claims to its insurer in excess of 10 percent of the employer's total claims during any quarter.

(4) An employer intentionally or repeatedly paying compensation in lieu of reporting to its insurer claims or accidents which may result in a compensable injury claim may be assessed a civil penalty by the Director.

(5) The insurer shall process and file claims and reports required by the Department in compliance with Chapter 656, WCD Administrative Orders and WCD Bulletins. Such filings shall not be made by facsimile transmission (FAX), unless specifically authorized by the Department. A "First Medical Report" Form 827, signed by the worker, is written notice of an accident which may involve a compensable injury under ORS 656.265. The signed Form 827 shall start the claim process, but shall not relieve the worker or employer of the responsibility of filing a Form 801.

(6) A claim required to be filed with the Director shall be reported to the Director within 21 days of the employer's date of knowledge. To meet this filing requirement, a Form 1502 accompanied by the Form 801 is to be submitted to the Department. However, when the Form 801 is not available within a time frame that would allow a timely filing, a Form 1502, accompanied by a signed Form[ed] 827 when available, will satisfy the initial reporting requirement. If the Form 801 is not submitted at the time of the initial filing of the claim, the Form 801 must be submitted within 30 days from the filing of the Form 1502. A Form 801 prepared by the insurer in place of obtaining the form from the employer/worker does not satisfy the filing requirement of the Form 801, unless the employer/worker cannot be located, or the form cannot be obtained from the employer/worker due to lack of cooperation.

(7) The Director may issue a civil penalty against any insurer delinquent in reporting or in submitting Forms 801, 1502, 1503 or 1644 with a late or error ratio in excess of ten percent during any quarter. For the purposes of this section, a claim or form shall be deemed to have been reported or submitted on the date it is received by the Department.

(8) Insurers are required to make an annual report to the Director reporting attorney fees, attorney salaries, and all other costs of legal services paid pursuant to ORS Chapter 656. The report shall be submitted on forms furnished by the Director for that purpose. Reports for each calendar year shall be filed not later than March 1 of the following year.

Stat. Auth.: ORS 656.264, ORS 656.265(6), ORS 656.726(3) and ORS 656.745
Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-100, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 1/3/92 as WCD Admin. Order 1-1992, eff. 2/1/92
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

NOTICE TO WORKER'S ATTORNEY

436-60-015 (1) When an injured worker's attorney has given written notice of representation prior or simultaneous written notice shall be given to the worker's attorney pursuant to ORS 656.331:

(a) When the Director or insurer requests the worker to submit to a medical examination; or

(b) When the insurer contacts the worker regarding any matter which may result in denial, reduction or termination of the worker's benefits.

(c) When the insurer contacts the worker regarding any matter relating to disposition of a claim pursuant to ORS 656.236.

(2) The Director shall assess a civil penalty against an insurer who intentionally or repeatedly fails to give notice as required under this rule.

Stat. Auth.: ORS 656.331 and ORS 656.745
Hist: Filed 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

RELEASE OF CLAIM DOCUMENTS TO CLAIMANT, BENEFICIARY AND ATTORNEY

436-60-017 (1) For the purpose of this rule:

(a) "Documents" include, but are not limited to, medical records, vocational records, written and automated payment ledgers for both time loss and medical services, payroll records, recorded statements, insurer generated records, all forms required to be filed with the Director, determination orders and notices of closure, and correspondence between the insurer, service providers, claimant, WCD and/or WCB.

(b) "Possession" means documents making up, or relating to, the insurer's claim record on the date of mailing the documents to the claimant, claimant's attorney or claimant's beneficiary. Any documents that have been received by the insurer five or more working days prior to the date of mailing shall be considered as part of the insurer's claim record even though the documents may not have yet reached the insurer's claim file.

(2) The insurer shall furnish, without cost, legible copies of documents in its possession relating to a claim, upon request of the claimant, claimant's attorney or claimant's beneficiary, at times other than those provided for under ORS 656.268 and OAR Chapter 438, as provided in this rule. Except as provided in OAR 436-60-180, a request by anyone other than the claimant or claimant's beneficiary shall be accompanied by an attorney retention agreement or an original medical release signed by the worker. Upon the request of the claimant's attorney, a request for documents shall be considered an ongoing request for future documents received by the insurer for 90 days after the initial mailing date under section (4) or until a hearing is requested before the Workers' Compensation Board. The insurer shall provide such new documents to claimant's attorney every 30 days, unless specific documents are requested sooner by the attorney. Such documents shall be provided within the time frame of section (4).

(3) Notwithstanding section (2), under the conditions set forth in OAR 436-10-030, the insurer may withhold from the claimant documents that contain psychological information or medical information marked confidential. However, the insurer shall inform the claimant when such a document has been withheld, and that the document will be, or has been, furnished to the claimant's attorney. If the claimant is unrepresented, the insurer shall inform the claimant that the document will be furnished upon receipt of written approval by the author of the document. The claimant shall have the responsibility of obtaining such approval.

(4) The insurer shall date stamp the request for copies of documents with the date it is received. The documents of open and closed files, and/or microfilmed files shall be mailed within 14 days of receipt of a request, and copies of documents of archived files within 30 days of receipt of a request. Documents are deemed mailed when addressed to the last known address of the claimant, claimant's beneficiary or claimant's attorney and deposited in the U.S. Mail.

(5) The documents shall be mailed directly to the claimant's or beneficiary's attorney, when the claimant or beneficiary is represented. If the documents have been requested by the claimant or beneficiary, the insurer shall inform the claimant or beneficiary of the mailing of the documents to the attorney. The insurer is not required to furnish copies to both the claimant or beneficiary and the attorney. However, if a claimant or beneficiary changes attorneys, the insurer shall furnish the new attorney copies upon request.

(6) The Director may assess a civil penalty against an insurer who fails to furnish documents as required under this rule. The matrix attached to these rules in Appendix "A" will be used in assessing penalties.

(7) When notified by the Director that a complaint has been filed, the insurer shall respond in writing to the Division. The response must be received within 21 days of the date of the Division's inquiry letter. A copy of the response including any attachments, must be sent simultaneously to the requestor of claim documents. If the Division does not receive a response within 21 days, a civil penalty may be assessed pursuant to OAR 436-60-200 against the insurer. Assessment of a penalty does not relieve the insurer of the obligation to provide a response.

(8) Civil penalties issued pursuant to this rule may be appealed under OAR 436-60-008.

Stat. Auth.: ORS 656.726(3) and ORS 656.745
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PAYMENT OF TEMPORARY TOTAL DISABILITY COMPENSATION

436-60-020 (1) An employer may pay compensation under ORS 656.262(4). Making such payments does not constitute a waiver or transfer of the insurer's duty to determine the worker's entitlement to benefits, or responsibility for the claim to ensure timely benefit payments. The employer shall provide adequate payment documentation as the insurer may require to meet its responsibilities.

(2) No compensation is due for temporary total disability suffered during the first three calendar days after the worker leaves work as a result of a compensable injury, unless the total disability is continuous for a period of 14 days or the worker is an inpatient in a hospital within the first period of time loss. The three day waiting period is three consecutive calendar days beginning with the day the worker first loses time from work as a result of the compensable injury, subject to the following:

(a) If the worker leaves work but returns and completes the work shift, that day shall not be considered the first day of the three day waiting period.

(b) If the worker leaves work and does not complete the work shift, that day shall be considered the first day of the three day waiting period.

(c) If the worker leaves work and does not complete the work shift, but returns to any type of work within 14 days of leaving work, no compensation is due for the three day waiting period.

(3) For workers employed with varying days off, the three day wait will be determined using the work schedule of the week the worker begins losing time from work. For such workers who are no longer employed with the employer at injury, the three day wait will be based on the work schedule of the week the worker was injured.

(4) No compensation is due and payable for any period of time where the insurer has requested from the worker's attending physician verification of the worker's inability to work and the physician cannot verify it pursuant to ORS 656.262(4)(b), unless the worker has been unable to receive treatment for reasons beyond the worker's control. Before withholding compensation under this section, the insurer shall inquire of the worker whether a reason beyond the worker's control prevented the worker from receiving treatment. If no valid reason is found or the worker refuses to respond or cannot be located, the insurer shall document its file regarding those findings. The insurer shall provide the Department a copy of the documentation within 20 days, if requested. When verification of temporary disability is received from the attending physician, the insurer shall pay compensation within 14 days of receiving the verification of any authorized period of time loss, unless otherwise denied.

(5) No compensation is due and payable when the medical service provider has exhausted its authority to authorize temporary disability payments and the worker has not received authorization for additional time loss from a provider qualified to be an attending physician. When the worker has failed to obtain such authorization, the insurer may terminate the payment of temporary disability when all three of the following apply:

(a) The insurer has provided prior notice to the worker explaining that the worker's temporary disability will terminate, unless the insurer has received written authorization of further temporary disability from an attending physician;

(b) The insurer has inquired of the worker whether the worker has obtained a new attending physician who has authorized ongoing time loss. If the worker does not have a new attending physician who has authorized ongoing time loss or the worker refuses to respond or cannot be located, the insurer shall document its file regarding those findings. The insurer shall provide the Department a copy of the documentation within 20 days, if requested; and

(c) The worker's failure to obtain authorization was within the worker's control. It is the worker's responsibility to ensure there is no lapse of authorization of time loss under this section.

(6) An insurer may suspend temporary disability benefits without authorization from the Division pursuant to ORS 656.262(4)(c) when all of the following circumstances apply:

(a) The worker has missed a regularly scheduled appointment with the attending physician;

(b) The insurer has sent a certified letter to the worker and a letter to the worker's attorney, at least 10 days in advance of a rescheduled appointment, stating that the appointment has been rescheduled with the worker's attending physician; stating the time and date of the appointment; and giving the following notice, in prominent or bold face type:

YOU MUST ATTEND THIS APPOINTMENT. IF THERE IS ANY REASON YOU CANNOT ATTEND, YOU MUST TELL US BEFORE THE DATE OF THE APPOINTMENT. IF YOU DO NOT ATTEND, AND DO NOT HAVE A GOOD REASON FOR NOT ATTENDING, YOUR TEMPORARY DISABILITY BENEFITS WILL BE SUSPENDED WITHOUT FURTHER NOTICE, AS PROVIDED BY ORS 656.262(4)(c).

(c) The insurer verifies that the worker has missed the rescheduled appointment;

(d) The insurer sends a letter to the worker, the worker's attorney and the Department giving the date of the regularly scheduled appointment that was missed, the date of the rescheduled appointment that was missed, the date of the letter being the day benefits are suspended, and the following notice, in prominent or bold face type:

SINCE YOU MISSED A REGULAR APPOINTMENT WITH YOUR DOCTOR, WE ARRANGED A RESCHEDULED APPOINTMENT. WE NOTIFIED YOU OF THE RESCHEDULED APPOINTMENT BY CERTIFIED MAIL AND WARNED YOU THAT YOUR BENEFITS WOULD BE SUSPENDED IF YOU FAILED TO ATTEND. SINCE YOU FAILED TO ATTEND THE RESCHEDULED APPOINTMENT WITHOUT PROVIDING A GOOD REASON, YOUR TEMPORARY DISABILITY BENEFITS HAVE BEEN SUSPENDED. IN ORDER TO RESUME YOUR BENEFITS, YOU MUST ATTEND A RESCHEDULED APPOINTMENT WITH YOUR DOCTOR WHO MUST VERIFY YOUR CONTINUED INABILITY TO WORK.

(7) When a worker with an accepted disabling compensable injury who has not been determined medically stationary is required to leave work for any single period of four hours or more to receive medical consultation, examination or treatment with regard to the compensable injury, the worker shall receive temporary disability benefits calculated pursuant to ORS 656.212 for the period during which the worker is absent. However, such benefits are not payable if the employer pays wages for the period of absence.

(8) When concurrent temporary disability is due the worker as a result of two or more claims, the insurers may petition the Division to make a pro rata distribution of compensation due under ORS 656.210 and ORS 656.212. The insurer shall provide a copy of the request to the worker, and the worker's attorney if represented. The insurers shall not unilaterally prorate temporary disability without the approval of the Division. The Division may order one of the insurers to pay the entire amount of temporary disability due or make a pro rata distribution between two or more of the insurers. The pro rata distribution ordered by the Division shall be effective only for benefits due as of the date all claims involved are in an accepted status. The order pro rating compensation will not apply to periods where any claim involved is in a deferred status.

(9) When concurrent temporary disability is due the worker as a result of two or more claims involving the same worker, the same employer and the same insurer, the insurer may make a pro rata distribution of compensation due under ORS 656.210 without an order by the Division. The worker shall receive compensation at the highest temporary disability rate of the claims involved.

(10) When a worker has a claim under a federal workers' compensation statute or the workers' compensation law of another state, territory, province, or foreign nation for the same injury or occupational disease as the claim filed in Oregon, the total amount of compensation paid or awarded under such other workers' compensation law shall be credited against the compensation due under Oregon workers' compensation law, upon approval by the Director. The worker shall be entitled to the full amount of compensation due under Oregon law. If Oregon compensation is more than the compensation under another law, or compensation paid the worker under another law is recovered from the worker, the insurer shall pay any unpaid compensation to the worker up to the amount required on the claim under Oregon law.

Stat. Auth.: ORS 656.210(2), ORS 656.245, ORS 656.262, ORS 656.307(1)(c), and ORS 656.726(3)
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RATE OF TEMPORARY DISABILITY COMPENSATION

436-60-025 (1) The rate of compensation shall be based on the wage of the worker at the time of injury, except in the case of an occupational disease, for which the rate of compensation will be based on the wage as outlined in ORS 656.210(2)(b)(B). Employers shall not continue to pay wages in lieu of statutory temporary total disability payments due. However, pursuant to ORS 656.018(4) the employer is not precluded from supplementing the amount of temporary total disability paid the worker. Employers shall separately identify workers' compensation benefits from other payments and shall not have payroll deductions withheld from such benefits.

(2) The rate of compensation for regularly employed workers shall be computed as outlined in ORS 656.210 and this rule. As used in this rule, "regularly employed" means actual employment or availability for such employment.

(a) Monthly wages shall be divided by 4.35 to determine weekly wages.

(b) For workers employed one or two days per week insurers shall use the worker's daily wage times three to arrive at a weekly wage (ORS 656.210).

(c) For workers employed through union hall call board insurers shall compute the rate of compensation on the basis of a five-day work week, regardless of the number of days actually worked per week.

(3) When the worker disagrees with the wage amount used, the insurer shall contact the employer to confirm the correct wage, or if a self-insured employer, the employer shall verify whether the correct wage amount was used. The insurer shall provide the worker an explanation of any wage change different from that reported on the claim Form 801.

(4) Computation of the rate of compensation for workers with minimal earnings and entitled to the lesser amount of 90 percent of wages a week or the amount of $50.00 is as follows:

(a) Ninety percent of weekly wages when the worker's wages are $55.56 or less per week;

(b) Fifty dollars when the worker's weekly wage falls between $55.56 and $75.00 per week; and

(c) Sixty-six and two-thirds percent of weekly wages when the worker's wages are $75.00 or more per week.

(5) The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule. The insurer shall resolve disputes regarding wage calculations by contacting the employer and worker to determine a reasonable wage. If an agreement cannot be reached, the dispute may be referred to the Division for resolution.

(a) For workers employed on call, paid hourly, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist and where there has been no change in the amount or method of the wage earning agreement, insurers shall use the actual weeks of employment with the employer at injury up to the previous 52 weeks. Where there has been a change in the amount or method of the wage earning agreement during the previous 52-week period, insurers shall use only the actual weeks under the wage earning agreement at time of injury. For workers employed less than four weeks, insurers shall use the intent of the most recent wage earning agreement as confirmed by the employer and the worker.

(b) For workers paid salary plus considerations (e.g. rent, utilities, food, etc.) insurers shall compute the rate on salary only if the considerations continue during the period the worker is disabled due to the injury. If the considerations do not continue, the insurer shall use salary plus a reasonable value of those considerations. Expenses incurred due to the job and reimbursed by the employer (e.g. meals, lodging, per diem, equipment rental) are not considered part of the wage.

(c) For workers employed in two jobs with two employers at time of injury insurers shall use only the wage of the job on which the worker was injured to compute the rate of compensation. Earnings from the second job will be considered for calculating temporary partial disability only to the extent that the post-injury income from the second job exceeds the pre-injury income from the second job (i.e., increased hours or increased wage).

(d) For workers employed where tips are a part of the worker's earnings insurers shall use the wages actually paid, plus the amount of tips required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of 1954, as amended, or the amount of actual tips reported by the worker, whichever amount is greater.

(e) Insurers shall consider overtime hours only when the worker worked overtime on a regular basis. Overtime earnings shall be included in the computation at the overtime rate. For example, if the worker worked one day of overtime per month, use 40 hours at regular wage and two hours at the overtime wage to compute the weekly rate. If overtime varies in hours worked per day or week, use the averaging method described in subsection (a). One-half day or more will be considered a full day when determining the number of days worked per week.

(f) Bonus pay shall be considered only when provided as part of the written or verbal employment contract as a means to increase the worker's wages. End-of-the-year and other one time bonuses paid at the employer's discretion shall not be included in the calculation of compensation.

(g) Incentive pay shall be considered only when regularly earned. If incentive pay earnings vary, use the averaging method described in subsection (a).

(h) Covered workers with no wage earnings such as volunteers, jail inmates, etc., shall have their benefits computed on the same assumed wage as that upon which the employer's premium is based.

(i) For workers paid by commission only or commission plus wages insurers shall use the worker's average commission earnings for previous 52 weeks, if available. For workers without 52 weeks of earnings, insurers shall use the assumed wage on which premium is based. Any regular wage in addition to commission shall be included in the wage from which compensation is computed.

(j) For workers who are sole proprietors, partners or officers of corporations insurers shall use the assumed wage on which the employer's premium is based.

(k) For school teachers or workers paid in a like manner, insurers shall use the worker's annual salary divided by 52 weeks to arrive at weekly wage. Temporary disability benefits shall extend over the calendar year.

(6) Compensation for the initial work day lost shall be paid for one-half day if the worker leaves the job during the first half of the shift and no compensation for the initial work day lost if the worker leaves the job during the second half of the shift.

(7) When a working shift extends into another calendar day, the date of injury shall be the date used for payroll purposes by the employer.

Stat. Auth.: ORS 656.210(2) and ORS 656.726(3)
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PAYMENT OF TEMPORARY PARTIAL DISABILITY COMPENSATION

436-60-030 (1) The amount of temporary partial disability (TPD) due an injured worker shall be based on the worker's earning power at any kind of work as demonstrated by the worker's employment history for the five years preceding the date of injury (including the job held at the time of injury). The worker's earning power is determined by the worker's wage at the time of injury, unless a higher weekly wage over the past five years can be documented by the worker.

(2) If the worker provides documentation of higher weekly wages from previous employment and is currently able to perform the regular duties of the highest wage job, the next highest wage job in which the worker is unable to perform the regular duties as a result of the injury shall be used to calculate TPD. If a worker is unable to perform the duties of a previous job due to conditions unrelated to the work injury, the wages of that job shall not be used to calculate TPD (e.g., previous amputation, blindness). For the purpose of this rule, the worker or worker's attorney may petition the insurer to consider relevant circumstances that prevent the worker from being able to perform previous jobs when determining the worker's earning power at any kind of work.

(a) If the insurer can demonstrate that the worker has voluntarily and permanently withdrawn from a previous job field with a higher wage or that such job field is no longer available to the worker, the wages of the job shall not be used to calculate TPD.

(b) If any of the worker's previous jobs in the prior five years has been with variable hours, shifts, workdays, wages, etc., the insurer shall determine the weekly wage of that job by using the average weekly wage earned for the last 52 weeks employment in that job with that employer, or the actual number of weeks if less than 52.

(3) The insurer shall review and determine loss of earning power at any kind of work whether or not the injured worker has returned immediately to modified employment at full wage. The worker shall be entitled to TPD so long as any post-injury wage is less than the earning power determined in sections (1) and (2). If TPD is due and payable, the claim shall be classified as disabling and must be reported to the Director pursuant to ORS 656.262. A worker who has physical or mental restrictions, but has been released to regular employment, shall not be entitled to TPD.

(4) To determine a worker's loss of earning power for the calculation of TPD when a worker has been released by the attending physician to modified employment, or is otherwise performing post-injury employment, the insurer shall immediately, and not later than 14 days of knowledge of release to modified employment or post-injury employment, notify simultaneously the worker, and the worker's attorney if represented, that:

(a) TPD will be determined using the wage at injury as the worker's highest earning power, unless they can provide documented evidence within 180 days of the notice that they had a job with a higher wage within the previous five years from the date of injury. That failure to respond within 180 days will waive their right to do so.

(b) Documented evidence of employment history must include, but may not be limited to: name, address and telephone number of each employer; type of occupation performed; description of job duties; dates of employment; and weekly wages received. For the purpose of this rule, documented evidence may include, but not be limited to, social security records, payroll slips, W-2 forms or any official document from the employer demonstrating employment at a higher earning power.

(c) Knowingly providing false information is punishable, upon conviction, by imprisonment for a term of not more than one year or by a fine of not more than $1,000, or by both pursuant to ORS 656.990(1).

(5) It will be the insurer's responsibility to verify the worker's wage earning power with the employer at injury.

(6) If the insurer believes the worker is able to perform any of the worker identified jobs in section (4), the insurer shall provide the attending physician with a description of the physical and any mental demands for the work duties of each job to determine which of the jobs the worker can currently perform within the current restrictions of the worker. The attending physician shall respond to the insurer's request for information in accordance with the reporting time frame established in OAR 436-10-030. The insurer shall direct the physician to bill for those services using CPT Code 99080 and for actual time spent on the report.

(7) The insurer shall redetermine the worker's earning power as prescribed by sections (1) and (2) within 14 days of receipt of all documentation of employment history as prescribed in section (4) and the attending physician's report, if needed. In no case shall the rate of TPD

exceed the rate of TTD. The insurer shall calculate and pay TPD actually due in accordance with this section and section (8). The insurer also shall determine whether or not any adjustment is due the worker for any difference in the rate of TPD used pursuant to section (4) for periods of temporary partial disability prior to the redetermination and, if necessary, issue an adjustment check for that time period. Any adjustment in favor of the worker for unpaid TPD ascertained following redetermination shall be issued by the insurer within 14 days of receipt of all documentation necessary to make the decision. Issuance of an adjustment check shall not interrupt or change the existing time loss payment schedule.

(8) The amount of temporary partial disability compensation due a worker shall be determined by:

(a) Subtracting post-injury wage earnings by the worker from any kind of work from

(b) The earning power as evidenced by the wage at the time of injury, unless a higher wage has been documented by the worker, as prescribed in sections (1) and (2); then

(c) Dividing the difference by the wage earnings used in subsection (b) to arrive at the percentage of loss of earning power; then

(d) Multiplying the current temporary total disability compensation rate by the percentage of loss of earning power in subsection (c).

(9) The worker is entitled to the post-injury wage at any employment plus TPD due as determined by the formula in section (8). Temporary disability is not due if any post-injury wages equal or exceed the worker's earning power as prescribed in sections (1) and (2).

(10) An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation from the date an injured worker begins any kind of wage earning employment prior to claim determination. If the worker is with a new employer and upon request of the insurer to provide wage information, it shall be the worker's responsibility to provide documented evidence of the amount of any wages being earned. Failure to do so shall be cause for the insurer to assume that post-injury wages are the same as or higher than the worker's highest earning power as determined by this rule.

(11) Temporary partial disability compensation paid under section (10) shall continue until:

(a) The attending physician verifies that the worker cannot continue working and is again temporarily totally disabled;

(b) The job no longer exists or the job offer is withdrawn by the employer. This includes, but is not limited, to termination of temporary employment, layoff or plant closure. A worker shall be included in this subsection who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim. The worker is entitled to temporary total disability compensation as of the date the job no longer is available. For the purpose of this rule, a worker quitting the job or the employer discharging the worker for violation of normal employment standards is not withdrawal of a job offer, but shall be considered the same as the worker failing to begin employment pursuant to ORS 656.268(3)(c);

(c) The compensation is terminated by order of the Department or by claim closure by the insurer pursuant to ORS 656.268; or

(d) The compensation has been paid for a cumulative total of two years.

(12) An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (8) as if the worker had begun the employment when an injured worker fails to begin wage earning employment pursuant to ORS 656.268(3)(c), under the following conditions:

(a) The attending physician has been notified by the employer or insurer of the physical tasks to be performed by the injured worker;

(b) The attending physician agrees the employment appears to be within the worker's capabilities; and

(c) The employer has confirmed the offer of employment in writing to the worker stating the beginning time, date and place; the duration of the job, if known; the wages; an accurate description of the physical requirements of the job and that the attending physician has found the job to be within the worker's capabilities.

(13) In determining failure on the part of the worker in section (12) and for purposes of Subsection (8)(a), "post-injury wages" are the wages the worker could have earned by accepting a job offer, or actual wages earned, whichever is greater, and any "unemployment compensation" received.

(14) Temporary partial disability compensation paid under section (10) shall continue until:

(a) The attending physician verifies the worker can no longer perform the job and is again temporarily totally disabled;

(b) The job no longer exists or the job offer is withdrawn under the same conditions as stated in subsection (11)(b). The worker is again entitled to temporary total disability compensation as of the date the job no longer is available.

(c) The compensation is terminated by order of the Department or by claim closure of the insurer pursuant to ORS 656.268; or

(d) The compensation has been paid for a cumulative total of two years.

(15) The insurer shall provide the injured worker and the worker's attorney a written notice of the reasons for changes in the compensation rate, and the method of computation, whenever a change is made.

(16) Failure to request the information required under this rule in a timely manner will subject the insurer to civil penalties under OAR 436-60-200.

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PAYMENT OF PERMANENT PARTIAL DISABILITY COMPENSATION

436-60-040 (1) If a claim is reopened as a result of an aggravation of the worker's condition and temporary total disability is due, any permanent partial disability benefits due shall continue to be paid concurrently with temporary total disability benefits.

(2) When training commences in accordance with OAR 436-120 after the issuance of a determination order, notice of closure, Opinion and Order of a Referee, Order on Review, or Mandate of the Court of Appeals, the insurer shall suspend any award payments due under the order or mandate and pay temporary disability benefits.

(3) The insurer shall stop temporary disability compensation payments and resume any suspended award payments upon the worker's completion or [the] ending of the training, unless the worker is not then medically stationary. If no award payment remains due, temporary disability compensation payments shall continue pending a subsequent determination order by the Division. However, if the worker has returned to work, the insurer may reevaluate and close the claim without the issuance of a determination order by the Division.

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PAYMENT OF COMPENSATION DURING WORKER INCARCERATION

436-60-045 (1) A worker is not eligible to receive temporary disability compensation for periods of time during which the worker is incarcerated for commission of a crime. All other compensation benefits shall be provided the worker as if the worker was not incarcerated. For the purpose of this rule:

(a) A worker is incarcerated for commission of a crime when:

(A) In pretrial detention, or

(B) Imprisoned following conviction for a crime.

(b) A worker is not incarcerated if the worker is on parole or work release status.

(2) Temporary disability compensation, if due and payable, shall be paid the worker within 14 days of the date the insurer becomes aware the worker is no longer incarcerated.

(3) A worker who is incarcerated shall have the same right to claim closure under ORS 656.268 as a worker who is not incarcerated. Any permanent disability awarded shall be paid the same as if the worker was not incarcerated.

Stat. Auth.: ORS 656.160
Hist: Filed 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 9/18/90 as WCD Admin. Order 19-1990, eff. 9/18/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 1/3/92 as WCD Admin. Order 1-1992, eff. 2/1/92

PAYMENT OF MEDICAL SERVICES: CHOICE OF ATTENDING PHYSICIAN

436-60-050

Hist: WCD 6-1981 (Admin), f. 12-23-81, ef. 1-1-82;
WCD 8-1983 (Admin), f. 12-29-83, ef. 1-1-84
Repealed by WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90

PAYMENT OF MEDICAL SERVICES ON NONDISABLING CLAIMS; EMPLOYER/INSURER RESPONSIBILITY

436-60-055 Pursuant to ORS 656.262(5) the costs of medical services for nondisabling claims, in amounts not to exceed $500 per claim, must first be paid by the insurer and the insurer may be reimbursed by the employer if the employer so chooses. Such choice does not relieve the employers of their claim reporting requirements or the insurers of their responsibility to determine entitlement to benefits and process the claims accurately and timely. Also, when paid by the employer, such costs cannot in any way be used to affect the employer's experience rating modification or otherwise be charged against the employer. To enable the Director to ensure these conditions are met, insurers and employers must comply with the following process and procedures:

(1) Notwithstanding the choice made by the employer pursuant to section (2) of this rule, the employer and insurer shall process the nondisabling claims in accordance with all statutes and rules governing claims processing. The employer, however, may reimburse the medical service costs paid by the insurer if the employer has chosen to make such payments. The method and manner of reimbursement by the employer shall be as prescribed in section (3) of this rule. In no case, however, shall the employer have less than 30 days to reimburse the insurer.

(2) Prior to the commencement of each policy year, the insurer shall send a notice to the insured or prospective insured, advising of the employer's right to reimburse medical service costs up to $500 on accepted, nondisabling claims. The notice shall advise the employer:

(a) Of the procedure for making such payments as outlined in section (3) of this rule;

(b) Of the general impact on the employer if the employer chooses to make such payments;

(c) That the employer is choosing not to participate if the employer does not respond in writing within 30 days of receipt of the insurer's notice;

(d) That the employer's written election to participate in the reimbursement program remains in effect, without further notice from the insurer, until the employer advises otherwise in writing or is no longer insured by the insurer; and

(e) That the employer may participate later in the policy period upon written request to the insurer, however, the earliest reimbursement period shall be the first completed period, established pursuant to subsection (3)(a) of this rule, following receipt of the employer's request.

(3) If the employer wishes to make such reimbursement, and so advises the insurer in writing, the procedure for reimbursement shall be:

(a) Within 30 days following each three month period after policy inception or a period mutually agreed upon by the employer and insurer, the insurer shall provide the employer with a list of all accepted nondisabling claims for which payments were made during that period and the respective cost of each claim.

(b) The employer, no later than 30 days after receipt of the list, shall identify those claims and the dollar amount the employer wishes to pay for that period and reimburse the insurer accordingly.

(c) Failure by the employer to reimburse the insurer within the 30 days allowed by subsection (3)(b) of this rule shall be deemed notice to the insurer that the employer does not wish to make a reimbursement for that period.

(d) Notwithstanding subsection (3)(b) of this rule, the employer and insurer may, by written agreement, establish a period in excess of thirty (30) days for the employer to reimburse the insurer.

(e) The insurer shall continue to bill the employer for any payments made on the claims within 27 months of the inception of the policy period. Any further billing and reimbursement will be made only by mutual agreement between the employer and the insurer.

(4) Insurers shall maintain records of amounts reimbursed by employers for medical services on nondisabling claims. Insurers, however, shall not modify an employer's experience rating or otherwise make charges against the employer for any medical services reimbursed by the employer. For employers on retrospective rated plans, medical costs paid by the employer on nondisabling claims shall be included in the retrospective premium calculation, but the amount paid by the employer shall be applied as credits against the resulting retrospective premium.

(5) If a claim changes from a nondisabling to a disabling claim and the insurer has recovered reimbursement from the employer for medical costs billed by the insurer prior to the change, the insurer shall exclude those amounts reimbursed from any experience rating, or other individual or group rating plans of the employer. If the employer is on a retrospective rated plan, premium calculation shall be as provided in section (4) of this rule.

(6) Insurers who do not comply with the requirements of this rule or in any way prohibit an employer from reimbursing the insurer pursuant to section (3) of this rule, shall be subject to a penalty as provided by OAR 436-60-200(6).

(7) Self-insured employers shall maintain records of all amounts paid for medical services on nondisabling claims in accordance with OAR 436-50-220. When reporting loss data for experience rating, the self-insured may exclude costs for medical services paid on nondisabling claims in amounts not to exceed $500 per claim.

Stat. Auth.: ORS 656.262(5) and ORS 656.745
Hist: Filed 12/18/87 as WCD Admin. Order 10-1987, eff. 1/1/88 (Temporary) as Rule 436-60-055
Amended 6/27/88 as WCD Admin. Order 4-1988, eff. 7/1/88 as Rule 436-60-055
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

LUMP SUM PAYMENT OF PERMANENT PARTIAL DISABILITY AWARDS

436-60-060 (1) The Director may approve an application of the worker for a lump sum payment of a permanent partial disability award ordered by the Division or as a result of litigation, exceeding 64 degrees, when the order has become final by operation of law or the worker and insurer have waived their right to appeal the adequacy of the award. When the insurer issues a Notice of Closure awarding permanent partial disability in excess of 64 degrees, only the worker must waive their right to appeal the adequacy of the award if the order has not become final by operation of law as the insurer cannot appeal its own order.

(2) For injuries occurring prior to August 9, 1983, insurers may make a lump sum payment of a permanent partial disability award not in excess of 64 degrees provided the worker is not asked to waive their right to appeal the adequacy of the award. For injuries occurring on or after August 9, 1983, where the award does not exceed 64 degrees, the insurer shall pay the award in a lump sum.

(3) Insurers may make a lump sum payment of a permanent partial disability award in excess of 64 degrees without authorization from the Director provided the worker is not asked to waive their right to appeal the adequacy of the award.

(4) Where the insurer chooses not to make a lump sum payment of a permanent partial disability award in excess of 64 degrees, the worker may apply to the Division, through the insurer, for an order directing the insurer to pay all or part of the unpaid award in a lump sum. Such need to apply to the Division continues for any additional award obtained through the appeal process that results in a total cumulative award in excess of 64 degrees, and where the value of the award, through periodic payments or offset, is reduced to 64 degrees or less. For the purpose of this rule, each opening of the claim is considered a separate claim and any subsequent permanent partial disability award from an aggravation reopening is a new and separate award. Applications for lump sum awards are subject to the law in effect at the time of the injury.

(5) A lump sum payment ordered in a litigation order or which is a part of a Claim Disposition Agreement (CDA) does not require further approval by the Division.

(6) The insurer shall submit the worker's application to the Division within 10 working days from the date the insurer receives the signed application from the worker.

(7) The application shall be in the form and format prescribed by the Director.

(8) The Division will not approve an application for lump sum payment when the worker has been found eligible for a vocational training program and will start the program within 30 days of the date of the decision on the lump sum request or is actively enrolled and engaged in a vocational training program under OAR 436-120; has temporarily withdrawn from such a program; or, the worker is involved in litigation affecting the permanent partial disability award.

(9) When the Division approves an application the insurer shall pay the lump sum amount to the worker within 5 working days after receipt of the order.

(10) If the application is denied in whole or in part by the Division, the worker may petition the Director to reconsider the application within 15 days of receipt of the denial. The decision of the Director upon reconsideration is final and not subject to further review.

(11) When a partial lump sum payment is approved, it shall be in addition to the regularly scheduled monthly payment. The remaining balance shall be paid pursuant to ORS 656.216.

(12) Denial or approval of an application does not prevent another application by the worker for a lump sum payment of all or part of any remainder of the award, provided additional justification is submitted.

Stat. Auth.: ORS 656.230
Hist: Filed 6/23/66 as WCB Admin. Order 6-1966
Amended 2/13/74 as WCB Admin. Order 5-1974, eff. 3/11/74
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-250, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

PAYMENTS TO ALIENS RESIDING OUTSIDE OF UNITED STATES

436-60-065

Hist: Filed 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Repealed 1/3/92 as WCD Admin. Order 1-1992, eff. 2/1/92

REIMBURSEMENT OF RELATED SERVICES COSTS

436-60-070 (1) The insurer shall notify the worker at the time of claim acceptance that actual and reasonable costs for travel, prescriptions and other claim-related services paid by the worker will be reimbursed by the insurer upon request. The insurer may require reasonable documentation to support the request. Insurers shall date stamp requests for reimbursement upon receipt and shall reimburse the costs within 30 days of receiving the worker's written request and supporting documentation, if the request clearly shows the costs are related to the accepted compensable injury or disease. On deferred claims, requests which are at least 30 days old at the time of claim acceptance become due immediately upon claim acceptance.

(2) Reimbursement of the costs of meals, lodging, public transportation and use of a private vehicle reimbursed at the rate of reimbursement for State of Oregon classified employes complies with this section. Reimbursement may exceed these rates where special transportation or lodging is needed.

(3) Requests for reimbursement denied as not being related to the accepted compensable injury or disease shall be returned to the worker within 30 days of the date of receipt by the insurer with an explanation of the reason for nonpayment. Requests which are at least 30 days old at the time of claim denial shall be returned immediately upon claim denial.

Stat. Auth.: ORS 656.245
Hist: Filed 10/23/69 as WCB Admin. Order 6-1969, eff. 10/29/69
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-270, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 1/3/92 as WCD Admin. Order 1-1992, eff. 2/1/92

CONSENT TO SUSPENSION OF COMPENSATION OR REDUCTION OF BENEFITS AWARDED THE WORKER

436-60-080

Hist: WCB 16-1970, f. 12-11-70, ef. 1-11-71
WCD 6-1978 (Admin), f. & ef. 4-27-78;
WCD 1-1980 (Admin), f. & ef. 1-11-80;
WCD 6-1981 (Admin), f. 12-13-81, ef. 1-1-82;
WCD 8-1983 (Admin), f. 12-29-83, ef. 1-1-84
Repealed by WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90

SUSPENSION OF COMPENSATION AND REDUCTION OF BENEFITS

436-60-085

Hist: Filed 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 6/8/92 as WCD Admin. Order 12-1992, eff. 7/1/92
Renumbered to OAR 436-60-095 and OAR 436-60-105 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION; WORKER'S FAILURE OR REFUSAL TO SUBMIT TO MEDICAL EXAMINATION

436-60-090

Hist: WCB 16-1970, f. 12-11-70, ef. 1-11-71
WCD 6-1978 (Admin), f. & ef. 4-27-78;
WCD 1-1980 (Admin), f. & ef. 1-11-80;
WCD 6-1981 (Admin), f. 12-13-81, ef. 1-1-82;
WCD 8-1983 (Admin), f. 12-29-83, ef. 1-1-84

MEDICAL EXAMINATIONS; SUSPENSION OF COMPENSATION AND NOTICE TO WORKER

436-60-095 (1) The Division will suspend compensation by order under conditions set forth in this rule. The worker shall have the opportunity to dispute the suspension of compensation prior to issuance of the order. The worker is not entitled to compensation during or for the period of suspension when the worker refuses or fails to submit to, or otherwise obstructs, a medical examination reasonably requested by the insurer or the Director. Compensation will be suspended until the examination has been completed. The conditions of the examination shall be consistent with conditions described in OAR 436-10-100. Any action of a friend or family member which obstructs the examination shall be considered an obstruction of the examination by the worker for the purpose of this rule. The Division may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination.

(2) The Division will consider requests to authorize suspension of benefits on accepted claims, deferred claims and on denied claims in which the worker has appealed the insurer's denial.

(3) A worker shall submit to medical examinations reasonably requested by the insurer or the Director. No more than three separate medical examinations may be requested by the insurer during each open period of a claim, except as provided under OAR 436-10. Examinations after the worker's claim is closed are subject to limitations in ORS 656.268(7). A claim for aggravation permits a new series of three medical examinations.

(4) The insurer may contract with a third party to schedule insurer requested medical examinations. If the third party notifies the worker of a scheduled examination on behalf of the insurer, the appointment notice is required to be sent on the insurer's stationery and must conform with the requirements of OAR 436-60-095(5).

(5) If an examination is scheduled by the insurer or by another party at the request of the insurer, the worker and the worker's attorney shall be notified in writing of the scheduled medical examination at least 10 days prior to the examination. The notice sent for each appointment, including those which have been rescheduled, shall contain the following:

(a) The name of the examiner or facility;

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

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

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

(e) If applicable, confirmation that the Director has approved the examination;

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

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

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

"YOU MUST ATTEND THIS EXAMINATION. IF THERE IS ANY REASON YOU CANNOT ATTEND, YOU MUST TELL THE INSURER AS SOON AS POSSIBLE BEFORE THE DATE OF THE EXAMINATION. IF YOU FAIL TO ATTEND OR FAIL TO COOPERATE, OR DO NOT HAVE A GOOD REASON FOR NOT ATTENDING, YOUR COMPENSATION BENEFITS MAY BE SUSPENDED IN ACCORDANCE WITH THE WORKERS' COMPENSATION LAW AND RULES, ORS 656.325 AND OAR 436-60."

(6) Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Resources, Children's Services Division, comply with this rule.

(7) If the worker fails to attend or cooperate in a medical examination required to determine the nature or need for further treatment, without reasonable cause, any further treatment shall be suspended until the worker cooperates.

(8) The request for suspension shall be sent to the Division. A copy of the request shall be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service as for a summons. The request shall include the following information:

(a) That the insurer requests suspension of benefits pursuant to ORS 656.325 and OAR 436-60-095;

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

(c) The dates of any prior insurer medical examinations the worker has attended in the current open period of the claim and the names of the examining physicians or facilities, or a statement that there have been no prior examinations, whichever is appropriate;

(d) A copy of any approvals given by the Director, or a statement that no approvals have been given, whichever is appropriate;

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

(f) The date and with whom failure to comply was verified;

(g) A copy of the letter required in section (5);

(h) Any other information which supports the request; and

(i) One of the following notices in prominent or bold face type:

For Accepted Claims:

"NOTICE TO WORKER: IF YOU THINK THIS REQUEST TO SUSPEND YOUR COMPENSATION IS WRONG, YOU SHOULD IMMEDIATELY WRITE TO THE WORKERS' COMPENSATION DIVISION, 21 LABOR & INDUSTRIES BUILDING, SALEM, OREGON 97310. YOUR LETTER MUST BE RECEIVED BY THE DIVISION WITHIN 10 DAYS OF THE DATE OF THIS REQUEST. IF THE DIVISION AUTHORIZES SUSPENSION OF YOUR COMPENSATION AND YOU DO NOT SUBMIT TO A MEDICAL EXAMINATION OF OUR CHOICE OR SHOW US A GOOD REASON WHY YOU CANNOT BE EXAMINED, WE WILL REQUEST THE WORKERS' COMPENSATION DIVISION TO CLOSE YOUR CLAIM."

For Deferred or Denied Claims:

"NOTICE TO WORKER: IF YOU THINK THIS REQUEST TO SUSPEND YOUR COMPENSATION IS WRONG, YOU SHOULD IMMEDIATELY WRITE TO THE WORKERS' COMPENSATION DIVISION, 21 LABOR & INDUSTRIES BUILDING, SALEM, OREGON 97310. YOUR LETTER MUST BE RECEIVED BY THE DIVISION WITHIN 10 DAYS OF THIS REQUEST. IF THE DIVISION GRANTS THIS REQUEST AND YOU DO NOT SUBMIT TO A MEDICAL EXAMINATION OF OUR CHOICE OR SHOW US A GOOD REASON WHY YOU CANNOT BE EXAMINED, YOU WILL NOT BE PAID COMPENSATION FOR THE PERIOD OF TIME DURING WHICH YOU DID NOT SUBMIT TO AN EXAMINATION IF YOUR CLAIM IS ACCEPTED IN THE FUTURE."

(9) If the Division consents to suspend compensation, the suspension shall be effective from the date the worker fails to attend an examination or such other date the Division deems appropriate until the date the worker undergoes an examination scheduled by the insurer or Director. Any delay in requesting consent for suspension may result in authorization being denied or the date of authorization being modified.

(10) The insurer shall assist the worker in meeting requirements necessary for the resumption of compensation payments. When the worker has undergone the examination, the insurer shall verify the worker's participation and reinstate compensation effective the date of the worker's compliance.

(11) If the worker makes no effort to reinstate compensation in an accepted claim within 60 days of the date of the consent order, the insurer shall submit a request for an administrative order of closure to the Division.

(12) If the Division denies the insurer's request for suspension of compensation, it shall promptly notify the insurer of the reason for denial. Failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.

(13) If an examination is scheduled by the Director, the insurer will notify the worker and the worker's attorney in writing as required in section (5) of this rule, except the notice in section (5)(h) shall be replaced with the following notice, in prominent or bold face type:

"YOU MUST ATTEND THIS EXAMINATION. IF YOU FAIL TO ATTEND OR FAIL TO COOPERATE, YOUR COMPENSATION BENEFITS SHALL BE SUSPENDED BY THE INSURER WITHOUT FURTHER NOTICE AS OF THE DATE OF THE EXAMINATION. IF YOU HAVE A VALID EXPLANATION JUSTIFYING YOUR ACTIONS, YOU MUST CONTACT THE DIVISION IMMEDIATELY."

(14) The Division may also take the following actions in regard to the suspension of compensation:

(a) Modify or set aside the order of consent before or after filing of a request for hearing.

(b) Order payment of compensation previously suspended where the Division finds the suspension to have been made in error.

(c) Reevaluate the necessity of continuing a suspension.

(15) An order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division of the Workers' Compensation Board.

Stat. Auth.: ORS 656.325
Hist: Filed 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended and Renumbered from OAR 436-60-085(1)(2)(4) 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION; WORKER'S FAILURE TO PARTICIPATE IN A PROGRAM AT A PHYSICAL REHABILITATION CENTER

436-60-100

Hist: WCD 6-1981 (Admin), f. 12-13-81, ef. 1-1-82;
WCD 8-1983 (Admin), f. 12-29-83, ef. 1-1-84
Repealed by WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90

SUSPENSION OF COMPENSATION FOR INSANITARY OR INJURIOUS PRACTICES, REFUSAL OF TREATMENT OR FAILURE TO PARTICIPATE IN REHABILITATION; REDUCTION OF BENEFITS

436-60-105 (1) The Division will suspend compensation by order under conditions set forth in this rule. The worker shall have the opportunity to dispute the suspension of compensation prior to issuance of the order. The worker is not entitled to compensation during or for the period of suspension when the worker commits insanitary or injurious acts which imperil or retard recovery; refuses to submit to medical or surgical treatment reasonably required to promote recovery; or fails or refuses to participate in a physical rehabilitation program.

(2) The insurer shall demand in writing the worker either immediately cease actions which imperil or retard recovery or immediately begin to change the inappropriate behavior and participate in activities needed to help the worker recover from the injury. Such actions include insanitary or injurious practices, refusing essential medical or surgical treatment, or failing to participate in a physical rehabilitation program. Each time the insurer sends such a notice to the worker, the written demand shall contain the following information, and a copy shall be sent simultaneously to the worker's attorney:

(a) A description of the unacceptable actions;

(b) Why such conduct is inappropriate;

(c) The date by which the inappropriate actions must stop, or the date by which compliance is expected; and,

(d) The following notice of the consequences should the worker fail to correct the problem, in prominent or bold face type:

"IF YOU CONTINUE TO DO INSANITARY OR INJURIOUS ACTS BEYOND THE DATE IN THIS LETTER, OR FAIL TO CONSENT TO THE MEDICAL OR SURGICAL TREATMENT WHICH WE BELIEVE IS NEEDED TO HELP YOU RECOVER FROM YOUR INJURY, OR FAIL TO PARTICIPATE IN PHYSICAL REHABILITATION NEEDED TO HELP YOU RECOVER AS MUCH AS POSSIBLE FROM YOUR INJURY, THEN WE WILL REQUEST THE SUSPENSION OF YOUR WORKER'S COMPENSATION BENEFITS. IN ADDITION, YOU MAY ALSO HAVE ANY PERMANENT DISABILITY AWARD REDUCED IN ACCORDANCE WITH ORS 656.325 AND OAR 436-60."

(3) For the purposes of this rule, failure or refusal to accept medical treatment means the worker fails or refuses to remain under a physician's care or abide by a treatment regimen. A treatment regimen includes, but is not limited to a prescribed diet, exercise program, medication or other activity prescribed by the physician which is designed to help the worker reach maximum recovery and become medically stationary.

(4) The insurer shall verify whether the worker complied with the request for cooperation on the date specified in section (2). If the worker initially agrees to comply, or complies and then refuses or fails to continue doing so, the insurer is not required to send further notice before requesting suspension of compensation.

(5) The request for suspension shall be sent to the Division. A copy of the request shall be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service as for a summons. The request shall include the following information:

(a) That the request for suspension is made in accordance with ORS 656.325 and OAR 436-60-105;

(b) A description of the actions of the worker which prompted the request, including whether such actions continue;

(c) Any reasons offered by the worker to explain the behavior, or a statement that the worker has not provided any reasons, whichever is appropriate;

(d) How, when and with whom the worker's failure or refusal was verified. Any delay in obtaining confirmation or in requesting consent for suspension of compensation may result in authorization being denied or the date of authorization being modified by the date of actual confirmation or the date the request is received by the Division;

(e) A copy of the letter required in section (2);

(f) Any other relevant information; and

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

"NOTICE TO WORKER: IF YOU THINK THIS REQUEST TO SUSPEND YOUR COMPENSATION IS WRONG, YOU SHOULD IMMEDIATELY WRITE TO THE WORKERS' COMPENSATION DIVISION, 21 LABOR & INDUSTRIES BUILDING, SALEM, OREGON 97310. YOUR LETTER MUST BE RECEIVED BY THE DIVISION WITHIN 10 DAYS OF THE DATE OF THIS REQUEST. IF THE DIVISION AUTHORIZES SUSPENSION OF YOUR COMPENSATION AND YOU DO NOT CORRECT YOUR UNACCEPTABLE ACTIONS OR SHOW US A GOOD REASON WHY THEY SHOULD BE CONSIDERED ACCEPTABLE, WE WILL REQUEST THE WORKERS' COMPENSATION DIVISION TO CLOSE YOUR CLAIM."

(6) If the Division concurs with the request, it shall issue an order suspending compensation from a date established under section (5) until the worker complies with the insurer's request for cooperation. Where the worker is suspended for a pattern of noncooperation, the Division may require the worker to demonstrate cooperation before restoring compensation.

(7) The insurer shall monitor the claim to determine if and when the worker complies with the insurer's requests. When cooperation resumes, payment of compensation shall resume effective the date cooperation was resumed.

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

(9) If the worker makes no effort to reinstate benefits within 60 days of the date of the consent order, the insurer shall submit a request for an administrative order of closure to the Division.

(10) If the Division denies the insurer's request for suspension of compensation, it shall promptly notify the insurer of the reason for denial. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.

(11) The Division may also take the following actions in regard to the suspension of compensation:

(a) Modify or set aside the order of consent before or after filing of a request for hearing.

(b) Order payment of compensation previously suspended where the Division finds the suspension to have been made in error.

(c) Reevaluate the necessity of continuing a suspension.

(12) An order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division of the Workers' Compensation Board.

(13) The Director may reduce any benefits awarded the worker under ORS 656.268 when the worker has unreasonably failed to follow medical advice, or failed to participate in a physical rehabilitation or vocational assistance program prescribed for the worker under ORS chapter 656 and OAR chapter 436. Such benefits shall be reduced by the amount of the increased disability reasonably attributable to the worker's failure to cooperate.

Stat. Auth.: ORS 656.325
Hist: Filed 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended and Renumbered from OAR 436-60-085(1)(2)(4)(5) 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION; WORKER'S COMMISSION OF INSANITARY OR INJURIOUS PRACTICES

436-60-110

Hist: WCB 16-1970, f. 12-11-70, ef. 1-11-71
WCD 6-1978 (Admin), f. & ef. 4-27-78;
WCD 1-1980 (Admin), f. & ef. 1-11-80;
WCD 6-1981 (Admin), f. 12-13-81, ef. 1-1-82;
WCD 8-1983 (Admin), f. 12-29-83, ef. 1-1-84;
Renumbered from 436-54-285, 5-1-85;
WCD 8-1985 (Admin), f. 12-12-85, ef. 1-1-86;
WCD 4-1987, f. 12-18-87, ef. 1-1-88
Repealed by WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90

REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION; WORKER'S REFUSAL TO SUBMIT TO MEDICAL OR SURGICAL TREATMENT: EVALUATION DIVISION REDUCTION OF PERMANENT PARTIAL DISABILITY AWARDED

436-60-120

Hist: WCB 16-1970, f. 12-11-70, ef. 1-11-71
WCD 6-1978 (Admin), f. & ef. 4-27-78;
WCD 1-1980 (Admin), f. & ef. 1-11-80;
WCD 6-1981 (Admin), f. 12-13-81, ef. 1-1-82;
WCD 8-1983 (Admin), f. 12-29-83, ef. 1-1-84
Renumbered from 436-54-286, 5-1-85;
WCD 8-1985 (Admin), f. 12-12-85, ef. 1-1-86;
WCD 4-1987, f. 12-18-87, ef. 1-1-88
Repealed by WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90

PETITION FOR REDUCTION OF BENEFITS; WORKER'S FAILURE TO FOLLOW MEDICAL ADVICE OR PARTICIPATE IN OR COMPLETE PHYSICAL RESTORATION OR VOCATIONAL REHABILITATION PROGRAMS OR COMMISSION OF INSANITARY OR INJURIOUS PRACTICES

436-60-130

Hist: WCB 16-1970, f. 12-11-70, ef. 1-11-71
WCD 6-1978 (Admin), f. & ef. 4-27-78;
WCD 1-1980 (Admin), f. & ef. 1-11-80;
WCD 6-1981 (Admin), f. 12-13-81, ef. 1-1-82;
WCD 8-1983 (Admin), f. 12-29-83, ef. 1-1-84
Renumbered from 436-54-286, 5-1-85;
WCD 8-1985 (Admin), f. 12-12-85, ef. 1-1-86;
WCD 4-1987, f. 12-18-87, ef. 1-1-88
Repealed by WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90

ACCEPTANCE OR DENIAL OF A CLAIM

436-60-140 (1) The insurer is required to conduct a "reasonable" investigation based on all available information in ascertaining whether to deny a claim. A reasonable investigation is whatever steps a reasonably prudent person with knowledge of the legal standards for determining compensability would take in a good faith effort to ascertain the facts underlying a claim, giving due consideration to the cost of the investigation and the likely value of the claim.

(2) In determining whether an investigation is reasonable, the Director will only look at information contained in the insurer's claim record at the time of denial. The insurer may not rely on any fact not documented in the claim record at the time of denial to establish that an investigation was reasonable.

(3) The insurer shall give the claimant written notice of acceptance or denial of a claim within (90) days of the employer's notice or knowledge of the claim.

(4) The Director may assess a penalty against any insurer delinquent in accepting or denying a claim beyond the (90) days prescribed in ORS 656.262 in excess of 5 percent of their total volume of reported disabling claims during any quarter.

(5) The notice of acceptance shall comply with ORS 656.262 and the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law. It shall specify to the worker:

(a) What conditions are compensable;

(b) Whether the claim is disabling or nondisabling;

(c) Of the Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that the injury is nondisabling by requesting a determination pursuant to ORS 656.268 within one year of the date of injury;

(d) Of the employment reinstatement rights and responsibilities under ORS Chapter 659;

(e) Of assistance available to employers from the Reemployment Assistance Reserve under ORS 656.622; and

(f) That expenses personally paid for claim related expenses up to a maximum established rate shall be reimbursed by the insurer when requested in writing and accompanied by sales slips, receipts, or other reasonable written support, for meals, lodging, transportation, prescriptions and other related expenses.

(6) The notice of denial shall comply with the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law and shall:

(a) Specify the factual and legal reasons for the denial; and

(b) Inform the worker of the Expedited Claim Service and of the worker's right to a hearing under ORS 656.283.

(7) The insurer shall send notice of the denial to each provider of medical services and health insurance when compensability of any portion of a claim for medical services is denied. When compensability of the claim has been finally determined or when disposition of the claim has been made, the insurer shall notify each affected service provider of the results of the determination or disposition. The notification shall include the results of the proceedings under ORS 656.236 or 656.289(4) and the amount of any settlement.

(8) The insurer shall pay compensation due pursuant to ORS 656.262 and 656.273 until the claim is denied, except where there is an issue concerning the timely filing of a notice of accident as provided in ORS 656.265(4). The employer may elect to pay compensation under this section in lieu of the insurer doing so. The insurer shall report to the Division payments of compensation made by the employer as if the insurer had made the payment.

(9) Compensation payable to a worker or the worker's beneficiaries while a claim is pending acceptance or denial does not include the costs of medical benefits or burial.

Stat. Auth.: ORS 656.262 and ORS 656.745
Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-300, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 6/8/92 as WCD Admin. Order 12-1992, eff. 7/1/92

DISPOSITION OF A CLAIM

436-60-145 (1) Pursuant to ORS 656.236(1) the parties to a claim(s) may dispose of any and all matters regarding the claim(s), except medical services and the worker's eligibility for preferred worker status in the claim, subject to the terms and conditions of this rule and OAR 438-09. The amendments to this rule are effective June 1, 1991 and apply to all claim disposition agreements filed with the Workers' Compensation Board on and after that date. If a claim disposition agreement involves more than one claim, the disposition shall contain all of the information required by this rule and OAR 438-09 for each claim including a separate first page of the claim disposition agreement as set forth in section (3).

(2) The insurer shall provide the claimant information explaining claim disposition in a separate enclosure accompanying the proposed claim disposition agreement. The Director shall prescribe by bulletin the specific form and format for the enclosure. If the claimant does not read or comprehend English, or is otherwise unable to understand written language, the insurer shall provide this information in a language or other manner which ensures the worker understands the meaning of claim disposition.

(3) For purposes of identification and data collection, the Director shall prescribe by bulletin a summary form and format for the first page of the claim disposition agreement which will include, but not be limited to, the following information:

(a) The worker's name;

(b) The case number assigned to the claim by the Board, if any;

(c) The insurer's claim number;

(d) The date of the compensable injury or disease;

(e) The file number assigned to the claim by the Division, if known;

(f) The worker's social security number;

(g) The name of the insurer;

(h) Specific identification of all benefits, rights and insurer obligations under Workers' Compensation Law which are released by the agreement;

(i) The total attorney fee, if any, to be paid to claimant's attorney;

(j) The total amount (excluding attorney fee) to be paid the claimant;

(4) The claim disposition agreement shall also contain, but not be limited to, the following:

(a) Identification of the accepted conditions that are the subject of the disposition;

(b) The date of the first claim closure, if any;

(c) The amount of any permanent disability award(s), if any

(d) Whether the worker has ever been able to return to the work force following the industrial injury or occupational disease;

(e) The worker's age, highest education level, and the extent of vocational training, including a list of occupations (or in the event that the worker is deceased, the age, highest educational level, and the extent of vocational training, including a list of occupations for each of the worker's beneficiaries);

(f) That the worker has been provided the informational enclosure prescribed by bulletin pursuant to section (2) of this rule; and

(g) The following notice in prominent or bold face type, which shall either be included in the claim disposition agreement or incorporated by reference into the agreement:

NOTICE TO CLAIMANT: YOU WILL RECEIVE A NOTICE FROM THE WORKERS' COMPENSATION BOARD TELLING YOU THE DATE THIS AGREEMENT WAS RECEIVED BY THEM FOR APPROVAL. YOU HAVE 30 DAYS FROM THE DATE THE BOARD RECEIVES THE AGREEMENT TO REJECT THE AGREEMENT, BY TELLING THE BOARD IN WRITING. DURING THIS 30 DAYS ALL OTHER PROCEEDINGS AND PAYMENT OBLIGATIONS OF THE INSURER, EXCEPT FOR MEDICAL SERVICES, ARE STAYED ON YOUR CLAIM. IF YOU DO NOT HAVE AN ATTORNEY, YOU MAY DISCUSS THIS AGREEMENT WITH THE BOARD IN PERSON, WITHOUT FEE OR CHARGE. TO CONTACT THE BOARD, WRITE OR CALL:

WORKERS' COMPENSATION BOARD
2250 McGilchrist Street SE
SALEM, OREGON 97310
TELEPHONE: (503) 378-3308, 8:00 TO 5:00, MONDAY THROUGH FRIDAY.

YOU MAY ALSO DISCUSS THIS AGREEMENT WITH THE WORKERS' COMPENSATION OMBUDSMAN WITHOUT FEE OR CHARGE. TO CONTACT THE OMBUDSMAN, WRITE OR CALL:

WORKERS' COMPENSATION OMBUDSMAN
LABOR & INDUSTRIES BUILDING
SALEM, OR 97310
TELEPHONE: (503) 378-3351, 8:00 TO 5:00, MONDAY THROUGH FRIDAY.

YOU MAY ALSO CALL THE WORKERS' COMPENSATION DIVISION'S INJURED WORKER HOTLINE, TOLL-FREE IN OREGON, AT 1-800-452-0288.

(5) Pursuant to OAR 438-09, the Board will not approve a claim disposition which lacks any of the elements described in this rule.

(6) Pursuant to ORS 656.236, reimbursement under ORS 656.506(3), 656.622, 656.625, or 656.628 for any claim disposition requires prior approval of the Director as prescribed in OAR 436-40, 436-45, 436-75 and 436-110.

(7) Where SAIF Corporation is the designated processing agent pursuant to ORS 656.054, reimbursement for any claim disposition under this rule requires prior approval of the Director.

(8) Payment of the disposition shall be made no later than the 14th day after the Board mails the agreement to the parties, unless otherwise stated in the agreement.

Stat. Auth.: ORS 656.236(1)
Hist: Filed 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 9/11/90 as WCD Admin. Order 18-1990, eff. 9/11/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 1/11/91 as WCD Admin. Order 1-1991, eff. 1/16/91 (Temporary)
Amended 4/18/91 as WCD Admin. Order 3-1991, eff. 6/1/91
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

TIMELY PAYMENT OF COMPENSATION

436-60-150 (1) Benefits are deemed paid when addressed to the last known address of the worker or beneficiary and deposited in the U.S. Mail. Payments falling due on a weekend or legal holiday as defined in ORS 187.010 may be paid on the last working day prior to or the first working day following the weekend or legal holiday. Subsequent payments may revert back to the payment schedule prior to the holiday.

(2) First payment of time loss must be timely. An insurer's performance is in compliance when 80% of payments are timely. The Director may assess a penalty against an insurer falling below these norms during any quarter.

(3) Compensation withheld pursuant to ORS 656.268(14) shall not be deemed untimely provided the insurer notifies the worker in writing why benefits are being withheld and the amount that must be offset before any further benefits are payable.

(4) Timely payment of temporary disability benefits means payment has been made no later than the 14th day after:

(a) The employer's notice or knowledge of the claim if temporary disability is immediate, unless the insurer cannot obtain verification of the worker's inability to work pursuant to ORS 656.262(4)(b);

(b) The employer's notice or knowledge of temporary disability related to but subsequent to the injury, unless the insurer cannot obtain verification of the worker's inability to work pursuant to ORS 656.262(4)(b);

(c) The start of vocational training pursuant to ORS 656.268(8), if the claim has previously been determined;

(d) The date the insurer has notice or knowledge of a medically verified inability to work due to an aggravation of the worker's condition under ORS 656.273. For the purpose of this subsection, compensation for authorized temporary disability is due and payable on a claim for aggravation, unless the claim is denied;

(e) The date of any Department order which orders payment of temporary disability. A request for reconsideration of a determination order does not stay payment of temporary disability compensation ordered. If an order has been appealed by the insurer pursuant to ORS 656.313, the appeal stays payment of temporary disability benefits except those which accrue from the date of the order;

(f) The date of a notice of claim closure issued by the insurer which finds the worker entitled to temporary disability.

(g) The date a notice of closure is set aside as premature.

(h) The date any litigation authorizing retroactive temporary disability becomes final. Temporary disability accruing from the date of the order shall begin no later than the 14th day after the date the order is issued;

(i) The date the Department refers a claim to the insurer for processing pursuant to ORS 656.029;

(j) The date the Department refers a noncomplying employer claim to SAIF Corporation; or

(k) The date a claim disposition is disapproved by the Board, if temporary disability benefits are otherwise due.

(l) The date the Department designates a paying agent pursuant to ORS 656.307.

(5) Temporary disability shall be paid to within seven (7) days of the date of payment at least once each 14 days. When making payments as provided in OAR

436-60-020(1), the employer may make subsequent payments of temporary disability concurrently with the payroll schedule of the employer, rather than at 14-day intervals.

(6) Permanent disability and fatal benefits shall be paid no later than the 30th day after:

(a) The date of a notice of claim closure issued by the insurer;

(b) The date of any determination or litigation order which orders payment of permanent total disability;

(c) The date of any Department order which orders payment of compensation for permanent partial disability or fatal benefits, unless the order has been appealed by the insurer pursuant to ORS 656.313. A request for reconsideration of a determination order does not stay payment of permanent partial disability compensation or fatal benefits ordered;

(d) The date any litigation authorizing permanent partial disability becomes final; or

(e) The date a claim disposition is disapproved by the Board, if permanent disability benefits are otherwise due.

(7) Subsequent payments of permanent disability and fatal benefits are made in monthly sequence as earned. The insurer may adjust monthly payment dates, but shall inform the beneficiary prior to making the adjustment. No payment period shall exceed one month without the Division approval.

(8) The insurer shall notify the beneficiary in writing when compensation is paid of the specific purpose of the payment, the time period for which the payment is made and the reimbursable expenses. The notice shall identify that portion of the claimed amounts for which reimbursement is denied.

Stat. Auth.: ORS 656.262
Hist: Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-310, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 1/3/92 as WCD Admin. Order 1-1992, eff. 2/1/92
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

PENALTY TO WORKER FOR UNTIMELY PROCESSING

436-60-155 (1) Pursuant to ORS 656.262(10), the Director may require the insurer to pay an additional amount to the worker as a penalty when the insurer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim. Penalties for unreasonable delay in payment of medical bills shall be processed in accordance with OAR 436-10.

(2) Requests for penalties under this section must be in writing, stating what benefits have been delayed or remain unpaid, and received by the Division within 180 days of the alleged violation.

(3) For the purpose of this section, "violation" is either:

(a) A late payment or the nonpayment of any single payment due, in which case a request for penalty must be received by the Director within 180 days of the date payment was due; or

(b) A continuous nonpayment or underpayment such as with yearly cost of living increases for temporary disability compensation. In these instances, a request for penalty must be received by the Director within 180 days of the date of the last underpayment. All prior underpayments will be considered as one violation, regardless of when the first underpayment occurred.

(4) When notified by the Director that additional amounts may be due the worker as a penalty under this rule, the insurer shall respond in writing to the Division. The response must be received by the Division within 20 days of the date of the Division's inquiry letter, with copies of the response, including any attachments, sent simultaneously to the worker and the worker's attorney (if represented). If an insurer fails to respond or provides an inadequate response (e.g. failing to answer specific questions or provide requested documents), assessment of a civil penalty may occur pursuant to OAR 436-60-200. In addition, failure to provide copies of the response to the worker and/or attorney timely may result in the assessment of a $50.00 civil penalty pursuant to OAR 436-60-200.

(5) When no written reason for delay is provided by the insurer as required in section (4) and no reason for the delay is evident from the worker's or Department's records, the delay shall be considered unreasonable, unless the worker has provided insufficient information to assess a penalty. In such cases, a civil penalty may be assessed pursuant to OAR 436-60-200.

(6) The Director will only consider a penalty issue where the assessment and payment of additional amounts described in ORS 656.262(10) is the sole issue of any proceeding between the parties. If a proceeding on any other issue is initiated before the Hearings Division of the Workers' Compensation Board between the same parties prior to the Director issuing an order under this section, and the Director is made aware of the proceeding, jurisdiction over the penalty proceeding before the Director shall immediately rest with the Hearings Division and result in referral of the proceedings to the Hearings Division. If the Director has not been made aware of the proceeding before the Hearings Division and issues a penalty order which becomes final, the penalty of the Director will stand.

(7) The Director will use the matrix attached to these rules in Appendix "B" in assessing penalties. When there are no "amounts then due" upon which to assess a penalty, no penalty will be issued under this rule.

(8) Penalties ordered under this rule shall be paid to the worker no later than the 30th day after the date of the order, unless the order is appealed. Failure to pay penalties in a timely manner will subject the insurer to civil penalties under OAR 436-60-200.

(9) Disputes regarding unreasonable delay or unreasonable refusal to pay compensation, or unreasonable delay in acceptance or denial of a claim may be resolved by the parties. In cases where the parties wish to resolve such disputes and the assessment and payment of additional amounts described in ORS 656.262(10) is the sole issue of a proceeding between the parties, and the violation(s) occurred within the last 180 days in accordance with section (3), then a stipulation must be submitted to the Division for approval. The stipulation must specify (a) the benefits delayed and the amounts, (b) the time period(s) involved, (c) if applicable, the name of the medical provider(s) and the date(s) of service(s) relating to medical bills, and (d) the amount of the penalty not to exceed 25 percent of the amount of compensation delayed.

(10) Payment of the penalty is due within 14 days after the date the Division approves the stipulation, unless otherwise stated in the stipulation. Failure to pay penalties in a timely manner will subject the insurer to civil penalties under OAR 436-60-200.

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

Stat. Auth.: ORS 656.262(10) and ORS 656.745
Hist: Filed 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 1/3/92 as WCD Admin. Order 1-1992, eff. 2/1/92
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

USE OF SIGHT DRAFT TO PAY COMPENSATION PROHIBITED

436-60-160 Insurers shall not use a sight draft to pay any benefits due a worker or beneficiary under ORS Chapter 656. Such benefits include temporary disability, permanent disability and reimbursement of costs paid directly by the worker.

Stat. Auth.: ORS 656.726(3)
Hist: Filed 12/19/75 as WCB Admin. Order 18/1975, eff. 1/1/76
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-315, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90

RECOVERY OF OVERPAYMENT OF BENEFITS

436-60-170 (1) Insurers may recover overpayment of benefits paid to a worker only as specified by ORS 656.268(13), unless authority is granted by a referee or the Workers' Compensation Board.

(2) Insurers shall explain in writing the reason, amount and method of recovery to the worker and the worker's attorney or to the worker's survivors.

Stat. Auth.: ORS 656.268(13)
Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff 1/1/84
Amended 4/4/84 as WCD Admin. Order 3-1984, eff 4/4/84
Renumbered from 436-54-320, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90

DESIGNATION AND RESPONSIBILITY OF A PAYING AGENT

436-60-180 (1) For the purpose of this rule:

(a) "Compensable injury" means an accidental injury or damage to a prosthetic appliance, or an occupational disease arising out of and in the course of employment with any Oregon employer, and which requires medical services or results in disability or death.

(b) "Exposure" means a specific incident or period during which a compensable injury may have occurred.

(c) "Responsibility" means liability under the law for the acceptance and processing of a compensable claim.

(2) The Division shall designate by order which insurer shall pay a claim if the employers and insurers admit that the claim is otherwise compensable, and where there is an issue regarding:

(a) Which subject employer is the true employer of a worker;

(b) Which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;

(c) Which of two or more employers or their insurers is responsible for paying compensation for two or more on-the-job injuries; or

(d) Which of two or more employers is responsible when there is joint employment.

(3) With the consent of the Workers' Compensation Board, Own Motion claims are subject to the provisions of this rule.

(4) Upon learning of any of the situations described in section (2), the insurer shall expedite the processing of the claim by immediately investigating the claim to determine responsibility and whether the claim is otherwise compensable.

(5) Upon learning of any of the situations described in section (2), the insurer shall immediately notify any other affected insurers of the situation. Such notice shall identify the compensable injury and include a copy of any disclaimer issued pursuant to ORS 656.308, all medical reports and other information pertinent to the injury. The notice shall identify each period of exposure which the insurer believes responsible for the compensable injury by the following:

(a) name of employer;

(b) name of insurer;

(c) specific date of injury or period of exposure; and

(d) claim number, if assigned.

(6) Insurers receiving notification from the Director or an insurer of a situation as described in section (2)(b) of this rule, shall consider it to be a report of claim forwarded by the employer pursuant to ORS 656.262(3). Notification from the Director or insurer of a situation as described in section (2)(a), (c) or (d) is not notice of a claim.

(7) Upon deciding that the responsibility for an otherwise compensable injury cannot be determined, the insurer shall request designation of a paying agent by applying in writing to the Division. Such a request, or agreement to designation of a paying agent, is not an admission that the injury is compensably related to that insurer's claim; it is solely an assertion that the injury is compensable against a subject Oregon employer. The insurer's application shall contain the following information:

(a) Identification of the compensable injury(s);

(b) That the insurer is requesting designation of a paying agent pursuant to ORS 656.307;

(c) That the insurer acknowledges the injury is otherwise compensable;

(d) That responsibility is the only issue;

(e) Identification of the specific claims or exposures involved by

(A) employer,

(B) insurer,

(C) date of injury or specific period of exposure, and

(D) claim number, if assigned;

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

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

(8) The Division will not designate a paying agent where there remains an issue of whether the injury is compensable against a subject Oregon employer, or if the 60 day appeal period of a denial has expired without a request for designation of a paying agent being received by the Division, or a request for hearing being received by the Board, or if an insurer included in the question of responsibility opposes designation of a paying agent because it has received no claim.

(9) When notified by the Division that there is a reasonable doubt as to the status of the claim or intent of a denial, the insurer shall provide written clarification to the Division, the worker, insurers involved and other interested parties within 20 days of the date of the notification. Failure to respond to the Division's inquiries in a timely manner will subject the insurer to civil penalties under OAR 436-60-200.

(10) Insurers receiving notice from the Division of a worker's request for designation of a paying agent shall immediately process the request in accordance with sections (4) through (7).

(11) Upon receipt of written acknowledgment from the insurers that the only issue is responsibility for an otherwise compensable injury claim, the Division will issue an order designating a paying agent pursuant to ORS 656.307. The Division will designate the insurer with the lowest compensation considering the following factors:

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

(b) If the temporary total disability rates and the rates per degree of permanent disability are the same, the earliest claim.

(c) If there is no temporary disability or the temporary total disability rates are the same, but the rates per degree of permanent disability are different, the claim with the lowest rate per degree of permanent disability.

(d) If one or more claims have disposed of benefits in accordance with ORS 656.236(1), the claim providing the lowest compensation not released by the claim disposition agreement.

(e) If one claim is under "Own Motion" jurisdiction, the Own Motion claim even if not the claim with the lowest temporary total disability rate.

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

(12) By copy of its order, the Division will refer the matter to the Workers' Compensation Board to set an arbitration proceeding pursuant to ORS 656.307 to determine which insurer is responsible for paying benefits to the worker.

(13) The designated paying agent shall process the claim as an accepted claim through determination unless relieved of the responsibility by an order of the arbitrator. The designated paying agent shall not settle any part of the claim by stipulated settlement or claim disposition agreement prior to the arbitrator's determination, except to resolve the issue of responsibility, unless prior approval and agreement is obtained from all potential responsible insurers. Compensation paid under the order shall include all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries. The payment of temporary disability due shall be for periods subsequent to periods of disability already paid by any insurer.

Stat. Auth.: ORS 656.307 and ORS 656.745
Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 4/29/80 as WCD Admin. Order 5-1980, eff. 4/29/80 (Temporary)
Amended 10/1/80 as WCD Admin. Order 7-1980, eff. 10/1/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-332, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temporary)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 1/3/92 as WCD Admin. Order 1-1992, eff. 2/1/92
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

ARBITRATION PROCEEDINGS COSTS ALLOCATION

436-60-185 The cost of the arbitration proceedings conducted by the Board pursuant to ORS 656.307 and OAR 438-14 shall be equally shared between the insurers involved in the arbitration proceedings as identified by the "Arbitrator's Decision" issued pursuant to OAR 438-14-025.

Stat. Auth.: ORS 656.307
Hist: Filed 12/18/87 as WCD Admin. Order 10-1987, eff. 1/1/88 (Temporary) as Rule 436-60-185
Amended 6/27/88 as WCD Admin. Order 4-1988, eff. 7/1/88 as Rule 436-60-185
Amended 1/3/92 as WCD Admin. Order 1-1992, eff. 2/1/92

MONETARY ADJUSTMENTS AMONG PARTIES AND DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

436-60-190 (1) An order of the Director pursuant to ORS 656.307 and OAR 436-60-180 applies only to the period prior to the order of the arbitrator determining the responsible paying party. Payment of compensation made thereafter shall not be recovered from the Consumer and Business Services Fund, unless the Director concludes payment was made before the arbitrator's order was received by the paying agent designated under OAR 436-60-180. Any monetary adjustment necessary after the arbitrator's order shall be handled under OAR 436-60-195.

(2) When all litigation on the issue of responsibility is final, the insurer ultimately held to be responsible shall, prior to paying any compensation, contact any nonresponsible insurer to learn what compensation has already been paid. When contacted by the responsible insurer, the nonresponsible insurer shall provide the requested information necessary for the responsible insurer to make a timely payment to the worker, medical providers or others, but in any case no later than 20 days after the date of the notification. Failure to respond to the responsible insurer's inquiry in a timely manner may result in non-reimbursement otherwise due from the responsible insurer or from the Consumer and Business Services Fund.

(3) The responsible insurer shall reimburse any nonresponsible insurers for compensation the nonresponsible insurer paid which the responsible insurer is responsible for, but has not already paid. Any balance remaining due the worker, medical providers or others shall be paid in a timely manner. Payment of compensation which results in duplicate payment to the worker, medical providers or others as a result of failing to contact the nonresponsible insurer shall not release the responsible insurer from the requirement to reimburse any nonresponsible insurers for its costs.

(4) The Division shall direct any necessary monetary adjustment between the parties involved which is not otherwise ordered by the Arbitrator or voluntarily resolved by the parties, but shall not order an insurer to pay compensation over and beyond that required by law, as it relates to the insurer's claim, except in the situation described in section (3). Failure to make monetary adjustments in a timely manner as ordered by the Division will subject the insurer to civil penalties under OAR 436-60-200. Only compensation paid as a result of an order by the Director pursuant to OAR 436-60-180 and consistent with this rule shall be recoverable from the Consumer and Business Services Fund when such compensation is not reimbursed to the nonresponsible insurer by the responsible insurer.

(5) When the Division determines improper or untimely claim processing by the designated paying agent has resulted in unnecessary costs, the Division may deny reimbursement from the responsible insurer and the Consumer and Business Services Fund.

(6) When the compensability of a claim becomes an issue after designation of a paying agent, the Division shall order termination of any further benefits due from the original order designating a paying agent.

The designated paying agent will be responsible for ensuring the issue of responsibility continues to hearing as well as joining the issue of whether the claim is a compensable injury claim. Failure to seek a conclusion to the issue of responsibility shall preclude recovery from the Consumer and Business Services Fund.

Stat. Auth.: ORS 656.307(3)
Hist: Filed 6/3/70 as WCB Admin. Order 5-1970
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 4/29/80 as WCD Admin. Order 5-1980, eff. 4/29/80 (Temporary)
Amended 10/1/80 as WCD Admin. Order 7-1980, eff. 10/1/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-334, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 1/3/92 as WCD Admin. Order 1-1992, eff. 2/1/92
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

MISCELLANEOUS MONETARY ADJUSTMENTS AMONG INSURERS

436-60-195 (1) The Director may order monetary adjustments between insurers under authority provided by ORS 656.726(3) and ORS 656.202 where a claimant has a right to compensation, but there is a dispute between insurers that does not fall under the Director's authority in ORS 656.307 and OAR 436-60-190. Any failure to obtain reimbursement from an insurer under this rule shall not be recoverable from the Consumer and Business Services Fund. The purpose of this rule is to ensure the claimant properly receives all compensation due under the workers' compensation law, but is not unduly compensated for more than the law intended.

(2) When any litigation on issues in question is final, insurers shall make any necessary monetary adjustments among themselves consistent with the determination of coverage for compensation paid to the worker, medical providers and others for which they are responsible and payment has not already been made. Any balance due after making such adjustments shall be paid in a timely manner to the worker, medical providers and others.

(3) The Division may direct any necessary monetary adjustment between parties, but shall not order an insurer to pay compensation over and beyond that required by law, as it relates to the insurer's claim, except where an insurer unduly compensates a claimant while having knowledge such compensation has already been paid by another insurer. Notwithstanding, each insurer has its own independent obligation to process its claim and pay interim compensation due until the claim is either accepted or denied. When notified by the Division that a dispute over monetary adjustment exists the insurer shall provide a written response to questions or issues raised, including supporting documentation, to the Division, insurers involved and other interested parties within 20 days of the date of the notification.

(4) Failure to respond to the Division's inquiries or make monetary adjustments in a timely manner as ordered by the Division will subject the insurer to civil penalties under OAR 436-60-200.

(5) When the Division determines improper or untimely claim processing by an insurer resulted in unnecessary costs, the Division may deny monetary adjustment between the insurers.

Stat. Auth.: ORS 656.726(3) and ORS 656.745
Hist: Filed 1/3/92 as WCD Admin. Order 1-1992, eff. 2/1/92
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

ASSESSMENT OF CIVIL PENALTIES

436-60-200 (1) The Director through the Division and pursuant to ORS 656.745 shall assess a civil penalty against an employer or insurer who intentionally or repeatedly induces claimants for compensation to fail to report accidental injuries, causes employes to collect accidental injury claims as off-the-job injury claims, persuades claimants to accept less than the compensation due or makes it necessary for claimants to resort to proceedings against the employer to secure compensation due. A penalty under this section will only be assessed after all litigation on the matter has become final by operation of the law. For the purpose of this section:

(a) "Intentionally" means the employer or insurer acted with a conscious objective to cause any result described in ORS 656.745(1) or to engage in the conduct so described in that section.

(b) "Repeatedly" means more than once in any twelve month period.

(2) Pursuant to ORS 656.745, the Director may assess a civil penalty against an employer or insurer who fails to comply with rules and orders of the Director regarding reports or other requirements necessary to carry out the purposes of the Workers' Compensation Law.

(3) An employer or insurer failing to meet the time frame requirements set forth in OAR 436-60-010, 436-60-017, 436-60-030, 436-60-060, 436-60-070, 436-60-155 and 436-60-180 may be assessed a civil penalty up to $1,000.

(4) An insurer who willfully violates OAR 436-60-160 shall be assessed a civil penalty of $1,000.

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

(6) Notwithstanding section (3) of this rule, an employer or insurer who does not comply with the claims processing requirements of ORS Chapter 656, and rules and orders of the Director relating thereto may be assessed a civil penalty of up to $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period.

(7) Any employer or insurer which misrepresents themselves in any manner to obtain workers' compensation claims records from the Director, or which uses such records in a manner contrary to these rules, is subject to a civil penalty of $1,000 for each occurrence. In addition, the Director may suspend or revoke an employer's or insurer's access to workers' compensation claims records for such time as the Director may determine. Any other person determined to have misrepresented themselves or who uses records in a manner contrary to these rules shall have access to these records suspended or revoked for such time as the Director may determine.

(8) For the purpose of section (6), statutory claims processing requirements include but are not limited to, ORS 656.202, ORS 656.210, ORS 656.212, ORS 656.228, ORS 656.234, ORS 656.236, ORS 656.245, ORS 656.262, ORS 656.263, ORS 656.264, ORS 656.265, ORS 656.268, ORS 656.273, ORS 656.307, ORS 656.313, ORS 656.325, ORS 656.331 and ORS 656.335.

(9) In arriving at the amount of penalty, the Division may consider, but is not limited to:

(a) The ratio of the volume of violations to the volume of claims reported, or

(b) The ratio of the volume of violations to the average volume of violations for all insurers or self-insured employers, and

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

(10) Insurer performance data is reviewed every quarter based on reports submitted by the insurer during the previous calendar quarter. Civil penalties will be issued for each of the performance areas where the percentages fall below the acceptable standards of performance as set forth in these rules. The standard for reporting claims to the Department will allow insurers to report claims by filing a Form 1502 accompanied by a Form 827 where the Form 801 is not available. Penalties will be issued in accordance with the matrix set forth in Appendix "C".

Stat. Auth.: ORS 656.202, ORS 656.210, ORS 656.212, ORS 656.228, ORS 656.234, ORS 656.236, ORS 656.245, ORS 656.262, ORS 656.263, ORS 656.264, ORS 656.265, ORS 656.268, ORS 656.273, ORS 656.307, ORS 656.313, ORS 656.325, ORS 656.331, ORS 656.335 and ORS 656.745
Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
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Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 4/18/91 as WCD Admin. Order 3-1991, eff. 6/1/91
Amended 1/3/92 as WCD Admin. Order 1-1992, eff. 2/1/92
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

ISSUANCE/SERVICE OF PENALTY ORDERS

436-60-210 (1) When a penalty is assessed as provided by OAR 436-60-200, the Division shall serve an order on the party, with a notice of the rights provided under ORS 656.740.

(2) The Division shall serve the Order by delivering a copy to the party in the manner provided by ORCP 7D.(3); or by sending a copy to the party by certified mail with return receipt requested.

Stat. Auth.: ORS 656.740
Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
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Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88
Amended 12/22/89 as WCD Admin. Order 7-1989, eff. 1/1/90
Amended 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

SUSPENSION AND REVOCATION OF AUTHORIZATION TO ISSUE GUARANTY CONTRACTS

436-60-220 (1) Pursuant to ORS 656.447, the Director may suspend or revoke the insurer's authority to issue guaranty contracts upon a determination that the insurer has failed to comply with its obligations under such contract or that it has failed to comply with the rules or orders of the Director.

(2) For the purpose of this rule:

(a) "Suspension" and its variations means a stopping by the Director of the insurer's authority to issue new guaranty contracts for a specified period of time.

(b) "Revocation" and its variations means a permanent revocation by the Director of an insurer's authority to issue guaranty contracts.

(c) "Show-cause hearing" means an informal meeting with the Director or designee in which the insurer shall be provided an opportunity to be heard and present evidence regarding any proposed orders by the Director to suspend or revoke an insurer's authority to issue guaranty contracts.

(3) Suspension or revocation under this rule will not be made until the insurer has been given notice and the opportunity to be heard through a show cause hearing before the Director and "show cause" why it should be permitted to continue to issue guaranty contracts.

(4) A show-cause hearing may be held at any time the Director finds that an insurer has failed to comply with its obligations under a guaranty contract or that it failed to comply with rules or orders of the Director.

(5) Following a show-cause hearing, the Director may rescind the proposed order if the insurer establishes to the Director's satisfaction its ability and commitment to comply with ORS Chapter 656 and these rules.

(6) A suspension may be in effect for a period of up to 18 months. A suspended insurer may continue to serve existing accounts and renew any existing policy, unless the policy lapses or is canceled during the period of suspension.

(7) After 12 months of the suspension has elapsed, the Division may audit the performance of the insurer. If the insurer is in compliance, the Administrator may request the Director to lift the suspension before the 18 months has elapsed. If the insurer is not in compliance, the Administrator may request the Director to revoke the insurer's authority to issue guaranty contracts.

(8) When an insurer's authority to issue guaranty contracts has been revoked, the insurer may serve an existing account only until the policy lapses, is canceled or until the next renewal date, whichever first occurs.

(9) After a revocation of an insurer's authority to issue guaranty contracts has been in effect for five (5) years or longer, it may petition the Director to restore its authority by submitting a plan in the form prescribed by the Director, demonstrating its ability and commitment to comply with the workers' compensation law, these rules and orders of the Director.

(10) Appeals of proposed and final orders of suspension and revocation issued under this rule may be made as provided in OAR 436-60-008.

(11) Any order of suspension or revocation issued by a referee or other person pursuant to ORS 656.447 and this rule is a preliminary order subject to revision by the Director.

Stat. Auth.: ORS 656.447
Hist: Filed 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90

60-WCDRULES/flr

(08-10-94)

APPENDIX "A"

436-60-017 Matrix for Assessing Penalties

VIOLATION NUMBER

NUMBER OF DAYS LATE	1	2	3	4	5+
1-7	$0	$100	$250	$500	$1,000
8-14	$100	$250	$500	$1,000	$1,000
15-21	$250	$500	$1,000	$1,000	$1,000
22+	$500	$1,000	$1,000	$1,000	$1,000

APPENDIX "B"

436-60-155 Matrix for Assessing Penalties

	VIOLATION NUMBER			
NUMBER OF DAYS LATE	1	2	3	4
1-2	0%	10%	20%	25%
3-7	5%	15%	25%	
8-14	10%	20%	25%	
15-21	15%	25%		
22 +	25%			

APPENDIX "C"

436-60-200 [(8)] Matrix for Assessing Penalties

Number of Quarters below Standard Performance Level Per Year

CATEGORY	1	2	3	4
801/827 Rec'd Timely	$50 each violation $250 Max	$100 each violation $500 Max	$150 each violation $750 Max	$200 each violation $1000 Max
1503 Rec'd Timely	$50 each violation $250 Max	$100 each violation $500 Max	$150 each violation $750 Max	$200 each violation $1000 Max
1644 Rec'd Timely	$50 each violation $250 Max	$100 each violation $500 Max	$150 each violation $750 Max	$200 each violation $1000 Max
Accept/Deny Timely	$50 each violation $250 Max	$100 each violation $500 Max	$200 each violation $1000 Max	$400 each violation $2000 Max
1st Payment Timely	$50 each violation $250 Max	$100 each violation $500 Max	$200 each violation $1000 Max	$400 each violation $2000 Max

60-WCDRULES/flr
(08-11-94)

For WCD Admin. Order No. 94-055

Exhibit "C"

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

In the Matter of the Amendment of Oregon Administrative Rule (OAR) Chapter 436, Division 60, Claims Administration	))))	SUMMARY OF TESTIMONY AND AGENCY RESPONSES

This document relates to the Order of Adoption, WCD Administrative Order 94-055. It constitutes and contains a summary of the significant data, views, and arguments contained in the hearing record.

The purpose of this summary is to provide the Director with a record of the agency conclusions about the major issues raised.

The amendment to the rules was announced in the Secretary of State's Administrative Rules Bulletin dated June 1, 1994. On June 16, and 21, 1994, public hearings were held as announced. The major issues raised were:

Rule OAR 436-60-(NEW):

Testimony: A new rule should be created to require all notices to claimants to be bilingual in the claimant's primary language. ("Q")

Response: To require all documents to be translated in the language of the worker may have a major cost impact on the system and needs to be analyzed before such a requirement is imposed. The Department is looking at the feasibility of providing insurers with translated versions of captions, appeal rights paragraphs and any appropriate procedural instructions, as well as translating Department documents with appeal rights paragraphs. The issue of whether such a requirement must be done by statute rather than rule also needs to be determined.

Rule OAR 436-60-009:

Testimony: Amend the rule to provide notice to the injured worker when his or her records are being requested. Such notice would ward off discriminatory hiring practices which was the intent of the amendments to the public records law. Any notice to the worker should be given prior to release, such as a ten-day notice prior to release of such records. ("b")

Response: The Department will not be providing claims history records to employers or organizations which provide records to employers. Therefore, there is no need to establish a paper record by giving notice to the worker. It is unnecessary to amend the rule.

Rule OAR 436-60-015:

Testimony: Amend the rule to preclude insurers from having personal contact with a represented worker and require a simultaneous copy of any written material sent to a worker. ("g"), ("U")

Response: The rule was adopted to carry out the provisions of ORS 656.331(1)(b) for situations where insurer contact affects the denial, reduction or termination of the worker's benefits. To require a simultaneous copy of any document (e.g. bi-weekly compensation checks, informational notices) is not in keeping with the intent of the statute. Furthermore, oral or written contact in the normal processing of a claim should not be restricted by rule. The rule remains as written.

Rule OAR 436-60-015(2):

Testimony: Amend the rule to change the civil penalty to a penalty payable to the worker with one-half of the penalty amount being paid to the worker's attorney as provided by statute. ("b")

Response: The statutory provision allowing for a penalty to be payable to the worker with one-half of the penalty amount being paid to the worker's attorney is found in ORS 656.262(10). Under this statute, a penalty may be assessed on any "amounts then due" for an insurer's unreasonable delay in paying compensation or in accepting or denying a claim. The proposed amendment to allow such a penalty under this rule would require legislative action to change the statute and cannot be adopted by rule. The rule remains as written.

Rule OAR 436-60-015(2):

Testimony: Amend the section to delete the language "intentionally or repeatedly" as it tends to defeat the intent of the penalty provision. ("b")

Response: The wording in the rule stating an insurer's failure to give notice be intentional or repeated for a civil penalty to be assessed is not intended to defeat the purpose of the penalty. Rather, it is intended to allow for discretion by the Director in enforcing compliance with the rule when an insurer inadvertently fails to give notice as required. The insurer may therefore be reprimanded and put on notice it has failed to comply with the rule and that further violations may subject it to the assessment of a penalty. As written, the rule allows for discretion by not mandating a maximum penalty for a single, inadvertent violation. The rule remains as written.

Rule OAR 436-60-017(2):

Testimony: Amend the section to require the claimant's attorney to confirm every 90 days that there is current representation for the worker regarding workers' compensation issues to eliminate the never-ending, ongoing request for documents. ("V")

Response: The section will be amended to reflect the concern of the testimony by adding to the second to the last sentence: " . . . considered an ongoing request for future documents received by the insurer for 90 days after the initial mailing date under section (4) or until a hearing is requested before the Workers' Compensation Board."

Rule OAR 436-60-017(2):

Testimony: Add language to the last sentence that only specific documents may be requested sooner than 30 days, and that such request expires at the resolution of an issue in litigation, unless renewed by the attorney. Otherwise the rule allows for request updates at any frequency of the attorneys choosing. ("G"), ("M")

Response: The section will be amended to address the concerns of the testimony regarding requesting specific documents by adding to the last line: " . . . unless specific documents are requested sooner by the attorney. Such documents shall be provided within the time frame of section (4)." Regarding the expiration of a request, the rule governs an insurer's responsibility to provide claim documents at times other than those provided for under ORS 656.268 and OAR Chapter 438. Thus, it is inappropriate to state that an ongoing request under this rule would expire at the resolution of an issue in litigation, since discovery issues during litigation would be governed by the Workers' Compensation Board's rules (OAR Chapter 438). Although otherwise amended in response to previous testimony concerning the limitation of an ongoing request, the rule remains as written.

Rule OAR 436-60-020(3):

Testimony: Amend the rule to delete the proposed language of establishing a worker with varying shifts and/or days off as a seven day-a-week worker as it causes problems for employers, unduly compensates workers, and increases vocational assistance costs for otherwise ineligible workers. The rule establishes the worker as a seven day a week worker, thus making the employer provide employment seven days a week in order to establish regular work or customary work. Also, the proposed rule would increase vocational assistance eligibility under OAR 436-120-040 as the employer could not offer seven day a week work. ("L")

Response: It was not the intent of the proposed section to make a worker a seven day-a-week worker for determining benefits, but only to establish a consistent and equitable method of making temporary disability payments to workers which may otherwise be harmed depending on their varying days off. However, other problems reflected in testimony need further study. For this reason, the proposed language as it relates to payment of temporary disability as if a seven day-a-week worker is being deleted. The section will still reflect that for workers with varying days off, the three day wait will be determined using the work schedule of the week the worker begins losing time from work.

Rule OAR 436-60-020(3):

Testimony: Amend the rule to shift all workers to a seven-day work week as it does not impact the specific wage that is given a worker, it makes it extremely easy to calculate benefits, it eliminates a significant number of requests from the Department for clarification as to scheduled days off, and it speeds up the process as days off do not need to be considered. Limiting the seven-day work week to only workers with varying shifts makes it extremely costly and cumbersome to an organization that has employers with both types of employees. ("c"), ("V")

Response: The section relating to payment of temporary disability as if a seven day a week worker has been deleted in response to previous testimony.

Rule OAR 436-60-020(3):

Testimony: Amend the rule to base the three day wait for workers with varying shifts on the work schedule of the week the worker was injured rather than the week the worker left work for consistency. The worker's time loss may begin some time after the injury when the worker may be unemployed or working for a new employer. ("G")

Response: The section is amended as it relates to the worker who is no longer employed with the employer at injury by adding language that for such workers the three day wait will be based on the work schedule of the week the worker was injured. For workers still employed with the employer at injury, the rule will remain as written so the worker is not harmed by varying days off that may delay the count of the three day wait.

Rule OAR 436-60-020(8):

Testimony: Amend the rule to allow for no limit on retroactive application of an order pro-rating compensation. Situations involving concurrent payment of compensation normally come to light some time later, and it is possible that some workers attempt to conceal the fact they are receiving benefits from two or more insurers at the same time. The rule is inequitable and will lead to increased litigation as it is probable a referee would order retroactive proration. ("G"), ("L")

Response: The section will be amended to reflect that an order pro-rating compensation may be applied retroactively to any periods where all claims involved are in an accepted status. The order pro-rating compensation will not be applied to periods where any claim involved is in a deferred status as the Court found in Petshow v. Portland Bottling Company, 62 Or App 614 (1983) that each insurer has a statutory obligation to pay compensation until the claim is denied.

Rule OAR 436-60-020(11):

Testimony: Amend the rule to clarify if the Department Form No. 440-1502 can be used for informing the worker and the worker's attorney of the changes in the compensation rate. ("M")

Response: The section has been deleted as the intent of the proposed section is already being met by OAR 436-60-015.

Rule OAR 436-60-025(5)(a):

Testimony: Amend the rule to define what is an "extended gap." ("g")

Response: Whether extended gaps in a worker's employment exist should be determined on a case-by-case basis. The Board has indicated in Adam J. Delfel, 44 Van Natta 524 (1992) that an extended gap is not based solely on the length of a break in work, but must also be based on whether the gap caused a change in the work relationship between employer and worker. The subsection remains as written as a general description of what is an extended gap cannot be sufficiently defined by rule to cover all situations.

Rule OAR 436-60-025(5)(b):

Testimony: Amend the rule to include per diem in wage calculation as there are many forms of employment where workers are seemingly reimbursed for expenses (e.g. reimbursement for chain saw

payments), yet it really is part of their overall expense package in dealing with a job. These payments continue while the worker is off work and not being able to make the payments makes it difficult to return to work. ("b")

Response: Per diem allowances and equipment rental costs are not considered elements of the worker's wage. When a worker no longer performs the duties, these expenses relating to the job no longer exist. Although some costs for providing equipment to perform a job may be a part of the employment agreement, they normally are not considered a part of the worker's wage. The subsection remains as written because payments on equipment would be no different than payments on clothing or an automobile in order to perform a job.

Rule OAR 436-60-030:

Testimony: Amend the rule to not allow the worker to receive higher wages at a modified job than he or she did at their regular job at time of injury, in addition to temporary partial disability. This erodes the Early Return to Work Program, as well as discourages the employer from offering a modified job and some employees from wanting to get off of modified work, as they could make more doing less. ("E"), ("F"), ("J"), ("O"), ("R")

Response: The Court of Appeals in Stone v. Whittier Wood Products, 124 OR App 117 (1993) ruled that insurers were to calculate a worker's temporary partial disability based on his or her "loss of earning power at any kind of work" without relying solely on wages earned at time of injury. The proposed rule complies with the ruling in Stone to consider the worker's earning power at any kind of work by basing it on the relevant circumstances of the worker demonstrated in the previous five years.

Testimony: Amend the rule to restrict the use of the new rule to situations where the worker has been terminated, and leave the original rule intact without running afoul of the Stone decision. ("f"), ("G"), ("M")

Response: The proposed amendment in the testimony would not be consistent with the ruling in the Stone case.

Testimony: Alternative No. 1 is preferred over Alternative No. 2 if the Department limits its options to only these two alternatives. Alternative No. 1 is less cumbersome and time-consuming and brings greater certainty to the process. ("b"), ("c"), ("e"), ("G"), ("K"), ("L"), ("M"), ("N"), ("P"), ("S"), ("V")

Response: Because no other alternatives are presented that comply with the ruling in Stone the proposed are limited to the alternatives presented. Given the testimony supporting Alternative No. 1, the Department will adopt Alternative No. 1 with modifications to clarify specific issues raised in other testimony.

Testimony: Amend the rule to apply an equitable implementation of the Stone decision by requiring earning power to be calculated on both the worker's theoretical earning power before the injury and the worker's theoretical earning power after the disability has become partial. The rule continues to use actual earnings in a modified job as the definition of post-injury earning power, while using a theoretical earning power prior to the injury. Temporary partial disability percentage would be determined by establishing theoretical post-release earning power based on such factors as physical limitations, job skills and the availability of employment. ("G")

Response: The Court in Stone only applied the worker's theoretical earning power before the injury in the formula to calculate TPD and made no reference to using anything but actual earnings for post-injury earnings in the formula.

Testimony: Amend the rule to include consideration of the value of a benefit package in determining earning power as some workers may accept a lower paying employment during a so-called relevant period because it includes benefits such as health insurance. In many cases the people are not aware until they are disabled from a work injury that they lose their health insurance while recovering from a work-related injury. ("b")

Response: Benefit packages provided by the employer are not for services rendered by the worker, but an employment benefit given in addition to one's wages or salary, and therefore are not considered part of wages for calculating temporary disability benefits. The rule remains as written.

Testimony: Amend the rule to have the insurers work out an agreement with the State of Oregon Employment Division to obtain a worker's five-year wage history. This would eliminate the need for the worker to gather wage information, and would shorten the entire process. ("W")

Response: Employment Division records may not be current or complete as wage information is reported quarterly. Also, the information may not be available for the most recent quarters or be available because the worker's previous employment was with an employer of another state. The rule remains as written.

Rule OAR 436-60-030(1):

Testimony: Amend the rule to shorten the five-year period as workers move from job to job with some employers through a bid process, as well as some workers move to a job that may be lower paid for reasons involving the job (e.g. does not require heavy lifting). Wages should be looked at that are truly lost. ("f")

Response: The fact that a worker may choose to "temporarily" move to a lower paying job does not affect the worker's true earning power. Using a shorter period of time may not accurately reflect the worker's earning power. The section remains as written.

Rule OAR 436-60-030(2):

Testimony: Amend the rule to allow for consideration that "extraordinary circumstances" (e.g. disabled from an unrelated car accident, victim of a disease, away on a personal mission) can be considered, or additional relevant circumstances can be considered by the petition of the worker or his or her attorney. The Stone decision indicated that "all relevant circumstances must be considered." ("b")

Response: The section is amended by adding language to allow the worker or worker's attorney to petition the insurer to consider relevant circumstances that prevent the worker from being able to perform previous jobs when determining the worker's earning power at any kind of work.

Rule OAR 436-60-030(2):

Testimony: Amend the rule to apply the 52 week average wage or similar fixed period of earnings to all cases. Simply having earned a higher wage for a brief time should not create any kind of presumption of the worker's earning power. There is no logic in averaging variable pay for 52 weeks if unvarying pay qualifies after having been earned for only a week or even less. Also, higher past wages should not be counted at all if they were earned for less time than the current wages have been earned. ("Y")

Response: The purpose of applying the 52 week average to a worker with variables in their work arrangement is to provide the worker with a fair assessment of their earning power, as well as be consistent with the application applied in OAR 436-60-025(5). Employment without variables assumes the wage remains the same whether for one week or for 52 weeks. Also, the length of employment has no affect on determining the worker's earning power at any kind of work. The rule remains as written.

Rule OAR 436-60-030(2):

Testimony: Amend the rule to clarify what "currently able to do the work" means. It should not mean "able to do the work if the person relocates to another economy where wages are higher than Oregon's" or "able to do the work if the person buys tools and equipment he or she does not now have or obtains a license he or she does not now have." It should mean "physically, economically, geographically, and legally ready and able to do the work at the present time." The court said to consider all of the relevant circumstances. ("Y")

Response: The statute does not restrict the worker to a physical, economical or geographical area. The language in statute regarding the worker's earning power at any kind of work implies that the worker may change his or her existing situation at time of injury in order to seek employment in any given job field in which they qualify. The rule remains as written.

Rule OAR 436-60-030(2)(a):

Testimony: Amend the rule to allow for situations where the worker has voluntarily withdrawn from a job field for personal reasons or while considering a career field change, but is still able to go back to that field of work and perform the work requirements. Many workers are trying other fields of work due to their own personal situations or the job market, but still are able to perform duties of higher paid jobs they may have voluntarily left on a permanent or temporary basis. ("b"), ("f"), ("g")

Response: The subsection is amended by adding the language "If the insurer can demonstrate that the worker has voluntarily and permanently withdrawn from a previous job field . . . ."

Rule OAR 436-60-030(2)(a):

Testimony: Amend the rule to require the worker to demonstrate that work at a higher pay level is available since they must document they had higher wages in the past five years. By requiring the insurer to demonstrate the worker voluntarily withdrew or that the job field is no longer available lays the ground work for an unnecessarily adversarial and litigious precedings. In most cases, logic or common sense suggests that if a worker could be earning more, he or she would be earning more. ("Y")

Response: The purpose of the rule is to identify when the worker has voluntarily and permanently withdrawn from a job field or a job field is no longer available to the worker for reasons unrelated

to the injury. It is not to determine whether or not there is work available to the worker at a higher pay level. Many workers are employed in other fields of work due to changes in job market or personal circumstances but are still able to perform duties of the higher paid jobs they left. The rule remains as written.

Rule OAR 436-60-030(2)(a):

Testimony: Amend the rule to recognize that its not whether a former job field is available, but a higher earning level is available. The worker should demonstrate that the higher earning level is presently available but for the injury or illness condition. ("Y")

Response: The worker's highest accomplished earning level in a given job field represents the worker's earning power in that type of an occupation for the purposes of this rule. Just because a worker may not be able to currently find a job with similar wages in a given job field does not mean the past wages of that job field should not be used to determine the worker's earning power at any kind of work. The rule remains as written.

Rule OAR 436-60-030(2)(a):

Testimony: Amend the rule to provide examples of acceptable logic or evidence that will acceptably demonstrate that a job field is no longer available to the worker, if the burden to demonstrate that a theoretical pay level can be regained is not placed on the worker. It is near to impossible to demonstrate that a theoretical job field cannot somehow be regained some where on earth. Clarification is needed as to which reasons are sufficient to demonstrate that the higher wage does not apply. If the rule is not clear, increased litigation will unnecessarily result. ("Y")

Response: The rule does provide examples such as amputation and blindness that would normally prevent a worker from returning to some job fields. The examples given in testimony (forced retirement, demotions, lay-offs, relocations, industry down-turns, professional sanctions or loss of licenses, failure to maintain continuing education and skills, criminal convictions, and removal from the higher paid job for incompetence) may apply in a given situation, but may not apply in all cases. However, the insurer may use these situations on a case by case basis if they can demonstrate that they prevent the worker from permanently returning to a job field. It is unnecessary to list such varying options in rule. The application of the examples in various situations can in itself invite litigation. The rule remains as written.

Rule OAR 436-60-030(4):

Testimony: Amend the rule to require the notification to the worker to include simultaneous notice to the worker's attorney when TPD is about to be paid and that documented evidence of a higher wage within the previous five years needs to be submitted. ("N")

Response: The section is amended by adding the language " . . . notify simultaneously the worker, and the worker's attorney if represented, that: . . . ."

Rule OAR 436-60-030(4)(a)

Testimony: Amend the rule to delete the 90 days for the worker to provide a work history or waive their right to do so, as this is contrary to TTD rules which has no limit to appeal the time loss rate. ("N"), ("W")

Response: Unlike TTD rules, this rule requires the insurer to notify the worker that they can provide documented evidence of a job with a higher wage to determine the worker's actual loss of earning power. This notification alerts the worker of their right to submit earning power history and the time frame brings closure to the issue. However, as a result of other testimony the time frame is changed from 90 days to 180 days of insurer notification.

Rule OAR 436-60-030(4)(a):

Testimony: Amend the rule to change the 90-day provision for a worker to respond to the insurer's communication to provide information about higher wages to 180-days from claim closure as many workers do not really anticipate what the final calculation of benefits is going to be until such time as they see claim closure. No harm is done as the insurer would pay TPD based on the job at injury and the worker could come forth with evidence as to earning power during the appeal time on a claim closure document and the information would be coordinated into the overall review of the compensation paid at that time. ("b")

Response: The worker is notified of their right to submit earning power history. The time frame to submit such information provides for early determination of appropriate benefits to the worker and brings closure to the issue. It is unreasonable and inappropriate to wait until claim closure to determine the worker's earning power to calculate the correct rate of temporary disability. However, as the 90-day period may be considered too restrictive, it is changed to 180-days of the notice by the insurer to be consistent with a similar time frame provided in OAR 436-60-155(2) to request ORS 656.262(10) penalties.

Rule OAR 436-60-030(4)(b):

Testimony: Amend the rule to require that a worker provide a written release for obtaining employment information. Requiring that a worker provide a signed release for the insurer (or Department) to verify wage and employment history, strength requirements of certain jobs and so forth, will only ensure that no untoward waste occurs. ("Z")

Response: The burden of proving a higher earning power is on the worker and not the insurer. The rule requires documented evidence be provided by the worker to the insurer. Written release to verify authenticity of these documents is unnecessary. The rule remains as written.

Rule OAR 436-60-030(6):

Testimony: Amend the rule to set a ten working day limit for a physician to respond to an insurers request for clarification whether a worker may be able to perform a type of work, and without a response the insurer may presume the worker is released for that type of work. The requirement that a description of all prior jobs be sent the physician will be time consuming for the physician and may result in no response at all. The time limit will allow for ongoing claim processing. ("c"), ("V")

Response: The rule only requires an insurer to obtain the physician's input on jobs they feel the worker is able to perform, not all prior jobs. The insurer must provide the physician with a description of the demands for the work duties for just those job. This reduces the time a physician must spend in reviewing the worker's file. In the mean time the worker continues to receive benefits based on the wage at time of injury. The section, however, will be amended by adding language similar to: "The attending physician shall respond to the insurer's request for information in accordance with the reporting time frame established in OAR 436-10-030."

Rule OAR 436-60-030(11)(b):

Testimony: Amend the rule to require the insurer to notify the worker of the intent to terminate benefits as a result of the employer discharging for violation of normal employment standards or the worker quitting the job, and allow the worker to have a prompt "hearing" with a representative of the Workers' Compensation Division. If the Division affirms the insurer's decision, benefits could be terminated and the worker may take the issue before the Hearings Division. ("W")

Response: Benefits to the worker is a matter of a worker's right to compensation to be heard before the Hearings Division. Disputes over dismissal from employment is a matter to be resolved by the Bureau of Labor and Industries pursuant to ORS Chapter 659. It is unreasonable to continue benefits to the worker pending resolution of a dispute, when the employer has acted in good faith and the worker's actions have removed the available employment. The subsection remains as written.

Rule OAR 436-60-030 Alt. 1 (12)(c) or Alt. 2 (10)(c):

Testimony: Amend the rule to address the situation of a worker who would have a job available if not for other reasons (e.g. termination due to violation of normal work practices, undocumented worker). ("S")

Response: The worker was employed at the time of injury. Any termination of employment or knowledge of an undocumented worker would have had to occur post-injury, and therefore should not be used to prevent the worker from receiving entitled compensation, except as described in Alt. 1 (11)(b) or Alt. 2 (9)(b). The subsection remains as written.

Rule OAR 436-60-055:

Testimony: Amend the rule to keep the existing rule which allows an employer to direct pay for medical services on non-disabling claims without going through the insurer. The proposed rule reverses cost control efforts by allowing an insurer to charge employers an additional administrative fee. ("L")

Response: The proposed language does not change the existing rule, but only clarifies the provision of section (1) of the rule. The option to the employer to make payments for medical services in amounts not to exceed $500 per nondisabling claim does not allow the employer to make direct payment of medical services to medical providers. This is clarified in Department Bulletin No. 210 dated March 1, 1990. The rule remains as written.

Rule OAR 436-60-060(8):

Testimony: Amend the rule to delete the proposed language relating to the worker not having a lump sum approved after being found eligible for a vocational training program, as some workers do not start their programs until sometimes much later. ("b")

Response: A worker participating in a vocational training program has their award suspended and temporary disability reinstated while in the program. The claim is then reevaluated for permanent disability upon completion of the program. It would be inappropriate to approve a lump sum payment of an award that may be reduced upon reevaluation when the worker is scheduled to start the program in a matter of days. Should the worker not start the program as scheduled, he or she may resubmit an application for a lump sum payment. The section is amended, however, to partially address the concern by adding a time frame in which the worker has been found eligible and will start the program within 30 days of the date of the decision on the lump sum request.

Rule OAR 436-60-095:

Testimony: Amend the rule to define the parameters of what is a "reasonable" location for the purposes of scheduling a medical examination under this rule. Without such definition, the worker does not know if the insurer will request suspension if the worker does not attend an examination he or she feels is scheduled in an unreasonable location nor does the worker know if the Department will authorize suspension in such situations. ("U")

Response: The rule addresses the notification requirements for scheduled medical examinations and suspension of compensation for the worker's failure to attend such examinations. It does not address the conditions concerning the medical examination; such clarification should be addressed in OAR 436-10. Moreover, variables such as the worker's condition and place of residence make it virtually impossible to define what a reasonable location would be for every circumstance. The rule remains as written.

Rule OAR 436-60-095(1):

Testimony: Amend the rule to clarify the meaning of "obstructs" a reasonably requested medical examination. It seems to place a substantial amount of discretion in the hands of the insurer about whether a worker's benefits may be suspended. ("W")

Response: It is the Division, not the insurer, which determines whether or not benefits should be suspended and whether special circumstances exist that would not warrant suspension of compensation. The rule remains as written.

Rule OAR 436-60-095(1):

Testimony: Amend the rule to clarify that insurer medical examinations shall not include vocational examinations. ("b")

Response: The rule addresses the notification requirements for scheduled medical examinations and suspension of compensation for the worker's failure to attend examinations. It does not address the conditions concerning medical examinations. This issue would be best addressed in testimony on the Division 10, Medical Services rules. The rule remains as written.

Rule OAR 436-60-095(2):

Testimony: Amend the rule to not adopt the proposed requirement that the Department will not suspend compensation in a denied claim as it is not consistent with ORS 656.325 and it infringes on the insurer's rights conferred by that statute. ("G"), ("K")

Response: The rule has been amended to reflect the testimony, as well as the notice requirement in OAR 436-60-095(8)(i), to make clear that the Department will consider requests to suspend compensation in any claim except denied claims in which the worker has not appealed, or where the denial is final.

Rule OAR 436-60-095(5)(h):

Testimony: Amend the rule to include in the notice paragraph a time period such as five days for the worker to notify the insurer if they are unable to attend the examination. ("M")

Response: If the insurer sends the notice by certified mail, which many do even though it is not required, the worker may not have 5 days left to contact the insurer, since the notice must only be sent 10 days prior to the examination. There are too many variables of why a worker cannot attend to place an arbitrary time frame in the rules. However, the rule is amended to address the concerns of the testimony by requiring the worker to notify the insurer as soon as possible when they are unable to attend. The notice is changed to read: " . . . IF THERE IS ANY REASON YOU CANNOT ATTEND, YOU MUST TELL THE INSURER AS SOON AS POSSIBLE BEFORE THE DATE OF THE EXAMINATION . . . "

Rule OAR 436-60-095(8)(i):

Testimony: Amend the rule to increase the worker's time period to respond to a suspension letter from 10 days to at least 21 or 30 days. Also, include advising the worker of the phone number within WCD, perhaps the ombudsman's phone number, to call regarding the request from the insurer. ("W")

Response: Since workers are given at least 10 days notice prior to the date of the examination of the consequences for failing to attend, and then are given another 10 days to respond to a suspension request, the Division finds adequate time is given for workers to respond. Additionally, phoned-in responses leave no documentation and would require the Division to rely on memory of the exact conversation. Such a "response" would then be open to interpretation as to what was actually said or meant by the worker. The rule remains as written.

Rule OAR 436-60-095(12):

Testimony: Amend the rule so the Department denies an insurer's request for suspension only for "substantial noncompliance" with the rules, and not for technicalities. ("G"). ("K")

Response: The section is amended by changing the language to advise that the Department may deny a suspension request for a material lack of conformance with the rule requirements.

Rule OAR 436-60-105(10):

Testimony: Amend the rule so the Department denies an insurer's request for suspension only for "substantial noncompliance" with the rules, and not for technicalities. ("G")

Response: The section is amended by changing the language to advise that the Department may deny a suspension request for a material lack of conformance with the rule requirements.

Rule OAR 436-60-140:

Testimony: Amend the rule to require the worker to cooperate in the insurer's investigation and processing of a claim by consenting to a recorded statement if requested by the insurer. ("Z")

Response: ORS 656.325 provides the only sanction for workers who fail to cooperate in the processing of their claim by the insurer: suspension of compensation until the worker attends the medical examination. If a worker refuses to provide a statement or provide other information required by the insurer to carry out its responsibility to conduct a reasonable investigation of the claim before determining compensability, the insurer can deny the claim. Denial of benefits to a recalcitrant worker which might otherwise be due is the sanction for failure to cooperate.

Absent specific statutory authority, the Director cannot make a rule to impose penalties and fees against workers beyond the "sanction" permitted under ORS 656.325. The rule remains as written.

Rule OAR 436-60-145(4)(a):

Testimony: Amend the rule to include a statement that the worker releases the specified rights to all conditions compensably related to the claim. The Board has balked at approving some CDA's for lack of specificity about the conditions being released. ("Z")

Response: The Board needs to know what accepted conditions are subject to the CDA. However, nothing precludes clarifying that the parties agree to release all rights with regard to the entire claim. The rule remains as written.

Rule OAR 436-60-145(4)(e):

Testimony: Amend the rule to not require information about the education and vocational training of deceased worker's survivors as it is an intrusion of personal information, not relevant to disposition of the claim (CDA), can be difficult to acquire, and can be of no statistical value. ("G"), ("N"), ("S"), ("V")

Response: The proposed requirement is important to the members of the Workers' Compensation Board in performing their review of the CDA to determine whether or not the CDA is unreasonable. Knowing the age, education, and vocational background of the beneficiaries assists the Board in evaluating whether the CDA should be approved, particularly where the beneficiaries are unrepresented and the proposed consideration for the CDA is relatively minimal. The subsection remains as written.

Rule OAR 436-60-155(4):

Testimony: Amend the rule to allow for the 20 days to respond to the Director's notification letter to be from the "receipt" date rather than from the date of the letter itself. ("M")

Response: Using the response due date based on the date of the letter allows all parties to be aware of the due date and assists the Department in resolving complaints in a timely manner. If the insurer needs more time to answer specific questions or obtain documentation requested in the Department's notification letter, it can timely respond to the Department in order to comply with this rule and explain why additional time is needed. The rule remains as written.

Rule OAR 436-60-155(4):

Testimony: Amend the rule as the assessment of a civil penalty for an inadequate response could be unfair if someone inadvertently does not respond appropriately to the request. It seems like double indemnity since there is already the possibility of a civil penalty for failing to respond. There could be a judgment call of whether someone answered the question satisfactorily. ("M")

Response: The amendment was proposed in order to gain greater compliance with this rule and to assure complete responses to the Director's inquiries. If an inadequate response is received, the Department's investigation is delayed by having to send more than one inquiry letter. If a second or third letter has to be sent because the insurer failed to provide the information requested in the first letter, the Department loses its ability to resolve complaints in a timely manner. As written, the rule does not require the assessment of a civil penalty, but rather allows for discretion. The rule remains as written.

Rule OAR 436-60-180(6):

Testimony: Amend the rule to put the burden of filing a claim on the worker as prescribed by ORS 656.308(2). ("Z")

Response: ORS 656.307(2)(b) applies to the situation of where more than one insurer of a certain employer is responsible for payment of compensation to the worker. The requirement of ORS 656.308(2) that the worker must file a claim for benefits against an employer or insurer is considered met when the worker files the first claim against that certain employer. It is then the responsibility of that certain employer to file the claim with the appropriate insurer. The rule remains as written.

Rule OAR 436-60-180(11)(d,e,f):

Testimony: Delete the proposed subsections as they are without a basis in law and are in fact illegal, in light of ORS 656.656.236. As proposed, these subsections have the possibility of requiring an insurer who has entered into a full CDA to reimburse another insurer, in excess of the original insurer's payment obligations as required by law. ("Z")

Response: The proposed subsections have not changed the intent of designating the insurer paying the lowest compensation as the paying agent. An insurer who has a full CDA would be designated as the paying agent as the only compensation due on that claim would be benefits under ORS 656.245. The purpose of designating

the insurer with the lowest compensation continues to be to avoid potential overpayments if an insurer with higher compensation is ultimately found the responsible paying agent. The rule remains as written.

Rule OAR 436-60-200(7):

Testimony: Delete the proposed rule since ORS Chapter 659 already contains a statutory remedy pertaining to the misuse of workers' compensation claims information. ("Z")

Response: ORS Chapter 659 applies only to employers which discriminate against workers. The statute is silent about insurers' and employers' access to claims information in the custody of the Director. The rule is intended to hold insurers and self-insured employers (which continue to have access) accountable for the proper use of claims information pursuant to ORS 192.502(18) and OAR 436-60-009. Any action of an employer contrary to ORS Chapter 659 remains in the jurisdiction of the Bureau of Labor and Industries. Absent this rule there is no accountability for the insurer which violates the condition that access (by law) is granted solely to assist in the processing of claims. The rule remains as written.

Having reviewed and considered all data, views and arguments presented, I hereby submit this report as a summary of statements given and exhibits received, and recommend the adoption of the amendments to the rules to correspond with the above responses to the testimony.

Dated this 15 day of August 1994.

WORKERS' COMPENSATION DIVISION

Susan C. Jordan

Susan C. Jordan, Presiding Officer

345-WCDBC/dwz
(08-15-94)

LIST OF PARTIES TESTIFYING
AT HEARING ON
DIVISION 60 RULES

ORAL TESTIMONY:

People Testifying at Hearing on June 16, 1994 in Salem, Oregon:

"a" Chris Davie, Government Affairs Coordinator, SAIF Corporation
"b" Mike Casey, Dobli & Associates
"c" Jan Reese, Risk Administrator, Grocers Insurance Group
"d" Albert Huntley, Injured Worker

People Testifying at Hearing on June 21, 1994 in Medford, Oregon:

"e" Lon Holston, AWPPW Local 89
"f" Henry Snow, Medite Corporation
"g" Michael Graham, Paralegal, Bischoff & Strooband

WRITTEN EXHIBITS:

"E" Garten Foundation, signed by Emil Graziani, Executive Director, dated May 17, 1994.

"F" Capital Concrete Construction, Inc., signed by Barbara C. Garcia, Corporate Secretary, dated May 24, 1994.

"G" SAIF Corporation, signed by Christopher J. T. Davie, CPCU, Government Affairs Coordinator, dated June 16, 1994.

"H" Albert Huntley, (Injured Worker), dated June 15, 1994.

"I" City of Corvallis, signed by Christina Zelazek, Personnel Analyst, dated June 15, 1994.

"J" Medite Corporation, signed by Connie J Gibbs, Personnel/Safety Director, dated June 17, 1994.

"K" Safeco Insurance, signed by Cathy Olson, Workers' Compensation Claims Manager, dated June 17, 1994.

"L" Cardinal Services, Inc., signed by Larry C. Holt, Workers' Compensation Coordinator, dated June 17, 1994.

"M" Sedgwick James, Inc., signed by Terri Rhodes, Vice President, Claims Manager, Claims Management Services, dated June 17, 1994.

"N" Gatti, Gatti, et al, Attorneys, signed by Curtis Morley, Paralegal, dated June 17, 1994.

"O" Garten Foundation, signed by Emil Graziani, Executive Director, dated June 15, 1994.

"P" Associated General Contractors, Oregon-Columbia Chapter, signed by Kevin Spellman, Chair, AGC Workers' Compensation Committee, dated June 21, 1994.

"Q" Oregon Legal Services Corporation, signed by Robert K. Flug, dated June 21, 1994.

"R" Mt. Bachelor, Inc., signed by Ann Smith and Pat Hatch, dated June 20, 1994.

"S" Liberty Northwest Insurance, signed by Gary Kentner, dated June 21, 1994.

"T" Max Rae, Attorney at Law, dated June 21, 1994.

"U" Bischoff & Strooband, Attorneys at Law, signed by Roger Ousey, dated June 20, 1994.

"V" Oregon Self-Insurers Association, signed by Ross E. Dwinell, Chairman, Legislative, dated June 27, 1994.

"W" Philip H. Garrow, Attorney at Law, dated July 6, 1994.

"X" SAIF Corporation, signed by Christopher J. T. Davie, CPCU, Government Affairs Coordinator, dated July 26, 1994.

"Y" Department of Administrative Services, Risk Management Division, signed by C. David White, Administrator, dated June 23, 1994.

"Z" Industrial Indemnity Company, signed by Gerald Wilson, Claims Supervisor, dated August 8, 1994.

"AA" SAIF Corporation, signed by Christopher J. T. Davie, CPCU, Government Affairs Coordinator, dated August 10, 1994.

345-WCDBC/DWZ

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

In the Matter of the Amendment of OAR Chapter 436, Workers' Compensation Division, Division 30, Claims Evaluation and Determination	))))	NOTICE OF EXTENSION FOR WRITTEN COMMENT

To All Interested Persons:

On May 13, 1994 the Director filed Notice Of Proposed Amendment of Rules advising all interested parties that the Workers' Compensation Division would hold public hearings on the above subject rules. The Notice was published in the Secretary of State's Bulletin dated June 1, 1994. Pursuant to the Notice, public hearings on the proposed rules were conducted on June 16, 1994 and June 21, 1994. The Notice further advised that in order to be considered, comments on the proposed rules were to be received no later than 5:00 pm, June 21, 1994.

Prior to and during the hearing, concerns were expressed by interested parties that they did not receive the proposed rules in time to study the amendments and make appropriate comments. In response to these concerns the Officer presiding over the hearing extended the period for interested persons to provide written comment on the rules to 5:00 pm, July 1, 1994.

Subsequent to the hearing, the Division completed its investigation into the reported delays in interested parties receiving their copies. The Division found that there were printing and mailing delays beyond normal processing time and that extending the time for receipt of written comments on the rule was appropriate. ORS 183.335(13) provides that in order to consider comments received after the date specified in the initial Notice of Proposed Amendment, the extension must apply equally to all interested persons. Since all interested parties were not at the hearings to be advised of the extension, the Division is providing this written notice of extension.

Accordingly, Notice is hereby given that the deadline for providing comments on the proposed rules as set forth in the NOTICE OF PROPOSED AMENDMENT OF RULES dated and filed with the Secretary of State on May 13, 1994 is extended until 5:00 pm, August 10, 1994. Comments may be submitted in writing to the Administrator, Workers' Compensation Division, Labor and Industries Building, Salem, Oregon 97310.

Dated this 1 day of July, 1994.

DEPARTMENT OF CONSUMER
AND BUSINESS SERVICES

Kerry Barnett, Director

DISTRIBUTION: B thru V;
X thru AA

WCDADMIN/2707

SED FORM
No. 425a
(Rev. 7/9/91)

DCBS Admin. Order 94-055

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SEC. OF STATE

CERTIFICATE AND ORDER
FOR FILING
PERMANENT
ADMINISTRATIVE RULES WITH THE SECRETARY OF STATE

I HEREBY CERTIFY that the attached copy is a true, full and correct copy of PERMANENT rule(s) adopted on August 11, 1994 (Date) by the Department of Consumer & Business Services (Department) (Division) to become effective August 28, 1994 (Date).

The within matter having come before the Department of Consumer and Business Services (Department) (Division) all procedures having been in the required form and conducted in accordance with applicable statutes and rules and being fully advised in the premises:

Notice of Intended Action published in Secretary of State's Bulletin: NO ( ) YES (x)
Date Published: June 1, 1994

NOW THEREFORE, IT IS HEREBY ORDERED THAT the following action be taken: (List Rule Number(s) or Rule Title(s) on Appropriate Lines Below)

Adopted:
(New total Rules) _____

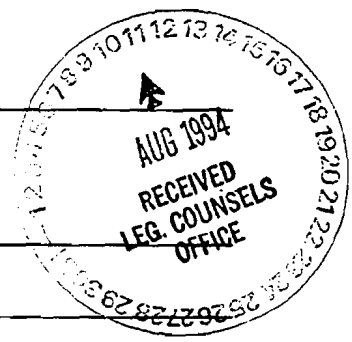
_____

Amended:
(Existing Rules) OAR 436-60

_____

Repealed:
(Total Rules Only) _____

_____



as Administrative Rules of the Department of Consumer and Business Services (Department) (Division)

DATED this 11th day of August, 19 94.

By: _____ (Authorized Signer)

Title: Kerry Barnett, Director

Statutory Authority: ORS 656.726(3) or
Chapter(s) _____ Oregon Laws 19___ or
House Bill(s) _____, 19__ Legislature: or Senate Bill(s) _____, 19__ Legislature
Subject Matter:

Div. 60 Claims Administration

For further Information Contact: Becky Miner Phone: 945-7504
(Rule Coordinator)

WCDPC1003/mkw