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 060, Claims Administration	))))	ORDER OF ADOPTION

The Director of the Department of Consumer and Business Services, pursuant to the general rule making 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 060, Claims Administration.

On August 15, 1996, the Workers' Compensation Division filed Notice of Public Hearing with the Secretary of State to amend rules governing Claims Administration. The Statement of Need and 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 436-001-0000 and to those on the Division's distribution mailing list as their interest indicated. The notice was published in the September 1, 1996, Secretary of State's Administrative Rule Bulletin.

On October 1, 1996, a public hearing was held as announced. In addition, the hearing record was held open for written testimony through 5:00 p.m. October 4, 1996. 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 the 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, Workers' Compensation Division, Labor & Industries Building, 350 Winter Street NE, Salem, Oregon 97310.

EXPLANATION: The Claims Administration, Oregon Administrative Rules 436, Division 060, have been amended to incorporate temporary rules in Administrative Orders 96-062 and 96-066 into permanent rules. The rules enable the department and industry staff to award time loss benefits at the time of closure in claims where authorized time loss is not documented, but files indicate periods of time that would reasonably be expected to result in compensable disability. The rules address insurers' and self-insured employers' obligation to document time loss authorization and clarify that certain events where such authorization is not documented be construed as authorization if supported by contemporaneous reports. The amendments to OAR 436-060-0020(6) are intended to be fully retroactive.

The rules provide for suspension of benefits for non-cooperation by the injured worker during the period prior to acceptance or denial of a claim. The rules further clarify that "personal and telephonic

interviews" may be audio or video taped by one or more of the parties. Additional notification requirements are required for non-cooperation because the injured worker refuses to attend an insurer medical examination. The amendments to OAR 436-060-0135(2), (3) and (5) are applicable effective June 7, 1995.

The rules clarify the method for calculating the weekly wages for "temporary" employees and the method of averaging wages where there has only been an increase or decrease in wages. Other general housekeeping was done for clarification of rules.

VERTICAL BARS IN THE RIGHT MARGIN INDICATE SIGNIFICANT CHANGES.

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

a. The applicable rule making 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 THAT:

(1) OAR Chapter 436, Division 060, Claims Administration, as set forth in Exhibit "A" attached hereto, is certified a true copy and hereby made part of this Order, are adopted effective November 27, 1996.
(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, Principal Documents Relied On and Statement of Fiscal Impact, 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 18th day of October, 1996.

DEPARTMENT OF CONSUMER
AND BUSINESS SERVICES

_____
Kerry Barnett, Director

Attachments

Distribution: WCD-ID, S, T, U, AT, CE, FM, IP, IA, LU, EG

CHAPTER 436

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

DIVISION 060

CLAIMS ADMINISTRATION

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EXHIBIT "A"

CHAPTER 436
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
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CLAIMS ADMINISTRATION

Authority for Rules

436-060-0001 These rules are promulgated under the Director's authority contained in ORS 656.210(2), 656.262(11), 656.264, 656.265(6), 656.325, 656.331 and 656.726(3).

Stat. Auth: ORS 656.210(2), ORS 656.262(11), ORS 656.264, ORS 656.265(6), ORS 656.325, ORS 656.331, ORS 656.704 and ORS 656.726(3)
Stat. Impltd: ORS 656.210(2), ORS 656.262(11), ORS 656.264, ORS 656.265(6), ORS 656.325, ORS 656.331, ORS 656.704 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 (Temp)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Purpose

436-060-0002 The purpose of these rules is to prescribe uniform standards by which insurers shall process workers' compensation claims pursuant to ORS 656.726(3). 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(11); and, to sanctions pursuant to ORS 656.447.

Stat. Auth: ORS 656.262(11), ORS 656.447, ORS 656.704 ORS 656.726(3) and ORS 656.745
Stat. Impltd: ORS 656.262(11), ORS 656.447, ORS 656.704 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 (Temp)
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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Applicability of Rules

436-060-0003 (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 656.262. Responsibility for processing and payment of compensation, sight drafts, claimant's duty to cooperate with an investigation, acceptance and denial and reporting of claims, and penalties for payment delays;

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

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

(g) ORS 656.268. Insurer claim closures, insurer recovery of overpayments;

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

(i) 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;

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

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

(2) The provisions of OAR 436-060-0020(6) are intended to be fully retroactive.

(3) The provisions of OAR 436-060-0135(2), (3) and (5) are applicable June 7, 1995.

Stat. Auth: ORS 656.210, ORS 656.212, ORS 656.230, ORS 656.262, ORS 656.264, ORS 656.265, ORS 656.268, ORS 656.307, ORS 656.325, ORS 656.331, ORS 656.704 and ORS 656.726(3)
Stat. Impltd: ORS 656.704 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 (Temp)
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
Amended 8/18/95 as WCD Admin. Order 95-058, eff. 8/18/95 (Temp)
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96
Amended 5/31/96 as WCD Admin. Order 96-062, eff. 5/31/96 (Temp)
Amended 8/5/96 as WCD Admin. Order 96-066, eff. 8/12/96 (Temp)
Amended 10/18/96 as WCD Admin. Order 96-070, eff. 11/27/96

Definitions

436-060-0005 For the purpose of these rules unless the context requires otherwise:

(1) "Aggravation" means an actual worsening of the compensable condition(s) after the last award or arrangement of compensation, which is established by medical evidence supported by objective findings, and otherwise satisfies the statutory requirements of ORS 656.273.

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

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

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

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

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

(7) "Inpatient" means an injured worker who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

(8) "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.

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

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

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

(12) "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 656.704 and ORS 656.726(3)
Stat. Impltd: ORS 656.704 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
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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 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temp)
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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Administration of Rules

436-060-0006 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 656.704 and ORS 656.726(3)
Stat. Impltd: ORS 656.704 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 12/29/83 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

436-060-0008 (1) Any party as defined by ORS 656.005(21), including an assigned claims agent 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 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 mailed or delivered to the Administrator within said 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 mailed or delivered to the Administrator within 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 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 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 mailed or delivered to the Administrator within 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
Stat. Implted: ORS 656.245, ORS 656.260, ORS 656.704, ORS 656.726(3) and ORS 656.740(1)
Hist: File 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 436-54-998, 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 (Temp)
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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Access to Department of Consumer and Business Services Workers' Compensation Claim File Records

436-060-0009 (1) Pursuant to ORS 192.430 and OAR 440-005-0015(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 440-005. 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 440-005.

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

(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 workers' 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 656.704 and ORS 656.726(3)
Stat. Impltd: ORS 656.704 and 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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Reporting Requirements

436-060-0010 (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. The report shall provide the information requested on the Form 440-801, and shall include, but not be limited to, the worker's name, address, and social security number, the employer's legal name and address, and the data specified by ORS 656.262 and ORS 656.265.

(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 ten 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 computer-printed forms, facsimile transmission (FAX), electronic data interchange (EDI), or other electronic means, 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.v

(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, or its electronic equivalent, 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 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, or the form is computer-printed based upon information obtained from the employer and worker.

(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 timely according to the provisions of ORS 656.726(3).

(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.

(9) When a claim is received and the insurer does not provide insurance coverage for the worker's employer on the date of injury, the insurer shall promptly forward the "non-insured" claim to the Director.

Stat. Auth: ORS 656.262, ORS 656.264, ORS 656.265(6), ORS 656.704, ORS 656.726(3) and ORS 656.745
Stat. Implted: ORS 656.262(13), ORS 656.264, ORS 656.265, ORS 656.704 and ORS 656.726(3)
Hist: WCB Order 4-1967, eff. 7/1/67
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
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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 (Temp)
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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Notice to Worker's Attorney

436-060-0015 (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;

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

(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, ORS 656.704, ORS 656.726(3) and ORS 656.745
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Release of Claim Documents

436-060-0017 (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 436-060-0180, 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. The signed medical release shall be in a form or format as the director may prescribe by bulletin. Information not otherwise available through this release, but relevant to the claim, may only be obtained in compliance with applicable state or federal laws. 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 436-010-0030, 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 mailed or delivered to the Director 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 requester of claim documents. If the Division does not receive a timely response, a civil penalty may be assessed pursuant to OAR 436-060-0200 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 436-060-0008.

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Payment of Temporary Total Disability Compensation

436-060-0020 (1) An employer may pay compensation under ORS 656.262(4) with the approval of the insurer pursuant to ORS 656.262(12). 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) Pursuant to ORS 656.210(3), no disability payment is due the worker for temporary total disability suffered during the first three calendar days after the worker leaves work as a result of a compensable injury, unless the worker is totally disabled after the injury and the total disability continues for a period of 14 consecutive days or unless the worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability. For the purpose of this rule, admittance as an inpatient to a hospital can be any time following the date of the injury, but must be within 14 days of the first onset of total disability to waive the three day waiting period. The three day waiting period is three consecutive calendar days beginning with the day the worker first loses time or wages from work as a result of the compensable injury, subject to the following:

(a) If the worker leaves work but returns and completes the work shift without loss of wages, that day shall not be considered the first day of the three day waiting period.

(b) If the worker does not complete the work shift, that day shall be considered the first day of the three day waiting period even if there is no loss of wages. For the purpose of this rule, an attending physician's authorization of time loss is not required to begin the waiting period; however, the waiting period would not be payable unless authorized.

(c) If the worker returns to any type of work within 14 days of leaving work, no disability

payment is due the worker for the three day waiting period. The three day waiting period, as it applies to loss of wages, is discussed in OAR 436-060-0030.

(3) For workers employed with varying days off or cyclic work schedules, the three day wait shall be determined using the work schedule of the week the worker begins losing time or wages as a result of the injury. For such workers who are no longer employed with the employer at injury or who do not have an established schedule at the time they begin losing time/wages, the three day wait and scheduled days off shall 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 in which the worker has withdrawn from the workforce. For the purpose of this rule, a worker has withdrawn from the workforce when:

(a) If, prior to reopening pursuant to ORS 656.273 or 656.278, the worker was not working and had not made reasonable efforts to obtain employment unless, but for the compensable injury, such efforts would be futile.

(b) A worker who was a full time student for at least six months in the 52 weeks prior to injury elects to return to school full time, unless the worker can establish a prior customary pattern of working while attending school. For purposes of this subsection, "full time" is defined as twelve or more quarter hours or the equivalent.

(5) 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)(c), 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. If the attending physician is unable to verify the worker's inability to work, the insurer may stop temporary disability payments and, in place of the scheduled payment, shall send the worker an explanation for stopping the temporary disability payments. 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.

(6) The insurer or self-insured employer shall verify and document temporary disability authorization from the attending physician within five days of the insurer's notice or knowledge of the worker's disability or claim. Authorization from the attending physician may be oral or written. The insurer, or the Department at time of claim closure or reconsideration, may infer authorization from such medical records as a surgery report or hospitalization record that reasonably reflects an inability to work because of the compensable claim, or from a medical report or chart note generated at the time of, and indicating, the worker's inability to work. No compensation is due and payable after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician pursuant to ORS 656.262(4)(f).

(7) An insurer may suspend temporary disability benefits without authorization from the Division pursuant to ORS 656.262(4)(d) 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 ten 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, your temporary disability benefits will be suspended without further notice, as provided by ORS 656.262(4)(d)."

(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, 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."

(8) When concurrent temporary disability is due the worker as a result of two or more accepted 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 Division's pro rata order shall not apply to any periods of interim compensation payable pursuant to ORS 656.262 and also does not apply to benefits pursuant to ORS 656.214 and ORS 656.245. Claims subject to the pro rata order approved by the Division shall be closed pursuant to OAR 436-030 and ORS 656.268, when appropriate. The insurers shall not unilaterally prorate temporary disability without the approval of the Division, except as provided in section (9) of this rule. The Division may order one of the insurers to pay the entire amount of temporary disability due or make a pro rata distribution between two or more of the insurers. 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 accepted 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 and ORS 656.212 without an order by the Division. The worker shall receive compensation at the highest temporary disability rate of the claims involved.

(10) If a closure pursuant to ORS 656.268 has been found to be premature and there was an open

ended authorization of temporary disability at the time of closure, the insurer shall begin payments pursuant to ORS 656.262, including retroactive periods, and pay temporary disability for as long as authorization exists or until there are other lawful bases to terminate temporary disability.

(11) If a denied claim has been determined to be compensable, the insurer shall begin temporary disability payments pursuant to ORS 656.262, including retroactive periods, if the time loss authorization was open ended at the time of denial, and there are no other lawful bases to terminate temporary disability.

Stat. Auth: ORS 656.210(2), ORS 656.245, ORS 656.262, ORS 656.307(1)(c), ORS 656.704 and ORS 656.726(3)
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Rate Of Temporary Disability Compensation

436-060-0025 (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(5) 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) Notwithstanding section (1), pursuant to ORS 656.262(4)(b), a self-insured employer may continue the same wage with normal deductions withheld (e.g. taxes, medical, and other voluntary deductions) at the same pay interval that the worker received at the time of injury. If the pay interval or amount of wage changes (excluding wage increases), the worker shall be paid temporary disability as otherwise prescribed by the workers' compensation law. The claim shall be classified as disabling. The rate of temporary total disability that would have otherwise been paid had continued wages not occurred and the period of disability will be reported to the Division.

(3) 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. Seasonal workers paid monthly shall have their weekly wages determined pursuant to OAR 436-060-0025(5).

(b) For workers employed through union hall call board insurers shall compute the rate of compensation on the basis of a five-day work week at 40 hours a week, regardless of the number of days actually worked per week.

(4) 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.

(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 seasonally, on call, paid hourly, paid by piece work or with varying hours, shifts or wages:

(A) 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, insurers shall use the actual weeks of employment (excluding any extended gaps) with the employer at injury up to the previous 52 weeks. For workers employed less than four weeks, insurers shall use the intent of the wage earning agreement as confirmed by the employer and the worker. For the purpose of this section, the wage earning agreement may be either oral or in written form.

(B)(i) Where there has been a change in the wage earning agreement during the 52 weeks prior to the date of injury due only to a pay increase or decrease, insurers shall use the worker's average weekly hours worked for the 52 week period, or lesser period as required in (5)(a)(A) of this subsection, multiplied by the wage at injury to determine the worker's current average weekly earnings.

(ii) Where there has been a change in the wage earning agreement during the 52 weeks prior to the date of injury due to a change of hours worked, change of job duties, or for other reasons either with or without a pay increase or decrease, insurers shall average earnings for the weeks worked under the most recent wage earning agreement, calculated by the method described in (5)(a)(A).

(iii) For workers employed less than four weeks under a changed wage earning agreement as described in this subsection, insurers shall use the intent of the most recent wage earning agreement as confirmed by the employer and the worker.

(b) Workers employed through a temporary service provider on a "temporary basis," or a worker-leasing company as defined in OAR 436-050, shall have their weekly wage determined by the method provided in subsection (a) of this rule. However, each job assignment shall not be considered a new wage earning agreement.

(c) 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.

(d) 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).

(e) 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.

(f) 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.

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

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

(i) 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.

(j) 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.

(k) For workers who are sole proprietors, partners, officers of corporations, or a limited liability company member including managers, insurers shall use the assumed wage on which the employer's premium is based.

(l) 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.

(m) For workers with cyclic schedules, insurers shall average the hours of the entire cycle to determine the weekly wage. For purposes of temporary disability payments, the cycle shall be considered to have no scheduled days off. For example: A worker who works ten hours for seven days, has seven scheduled days off, then repeats the cycle, is considered to have a 14 day cycle. The weekly wage and payment schedule would be based on 35 hours a week with no scheduled days off.

(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.

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Payment of Temporary Partial Disability Compensation

436-060-0030 (1) Pursuant to ORS 656.212(1), when the worker's disability is or becomes partial only and is temporary in character, no disability payment is due the worker for temporary partial disability suffered during the first three calendar days after the worker leaves work or loses wages as a result of a compensable injury. The three day waiting period is three consecutive days beginning with the day the worker first loses time from work or loses wages as a result of the compensable injury subject to the following:

(a) If the worker leaves work but returns and completes the work shift without loss of wages, that day shall not be considered the first day of the three day waiting period.

(b) If the worker leaves work but returns and completes the work shift and receives reduced wages, that day shall be considered the first day of the three day waiting period.

(c) If the worker does not leave work but receives reduced wages, that day shall be considered the first day of the three day waiting period.

(d) If the worker does not complete the work shift, that day shall be considered the first day of the three day waiting period even if there is no loss of wages. For the purpose of this rule, an attending physician's authorization of time loss is not required to begin the waiting period.

(2) 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 wage used to compute the rate of compensation at the time of injury; 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).

(3) Notwithstanding section (2), for workers whose rate of compensation is based on an assumed wage, "post-injury wage earnings" will be that proportion of the assumed wage which the hours worked during the period of temporary partial disability represent as a percentage of the hours worked prior to the injury.

(4) An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (2) 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 wages at time of injury.

(5) An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (2) 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.

(6) Pursuant to ORS 656.325(5)(b), the insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (2) as if the worker had begun the employment when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had not been terminated from employment for violation of work rules or other disciplinary reasons, under the following conditions:

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

(b) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (2);

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

(d) The attending physician agrees the employment appears to be within the worker's capabilities.

(7) Pursuant to ORS 656.325(5)(c), the insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (2) as if the

worker had begun the employment when the attending physician approves employment in a modified job whether or not such a job is available if the worker is a person present in the United States in violation of federal immigration laws, under the following conditions:

(a) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (2);

(b) The attending physician has been notified by the employer or insurer of the physical tasks that would have been performed by the injured worker; and

(c) The attending physician agrees the employment appears to be within the worker's capabilities.

(8) Temporary partial disability shall be paid at the full temporary total disability rate as of the date a modified job no longer exists or the job offer is withdrawn by the employer. This includes, but is not limited to, termination of temporary employment, layoff or plant closure. A worker who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim shall be included in this section. For the purpose of this rule, when a worker who has been doing modified work quits the job or the employer terminates the worker for violation of work rules or other disciplinary reasons it is not a withdrawal of a job offer by the employer, but shall be considered the same as the worker refusing wage earning employment pursuant to ORS 656.325(5)(a). This section does not apply to those situations described in sections (5), (6) & (7) of this rule.

(9) When the worker's disability is partial only and temporary in character, temporary partial disability compensation pursuant to ORS 656.212 shall continue until:

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

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

(c) The compensation has been paid for an aggregate period of two years. For the purpose of this rule, each opening of the claim is considered a separate claim and establishes a new two year period; or

(d) The compensation is lawfully suspended, withheld or terminated for any other reason.

(10) In determining failure on the part of the worker in section (5) and for purposes of subsection (2)(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, sick or vacation leave payments received.

(11) 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.

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Amended 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temp)
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
Amended 8/18/95 as WCD Admin. Order 95-058, eff. 8/18/95 (Temp)
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96
Amended 10/18/96 as WCD Admin. Order 96-070, eff. 11/27/96

Payment of Permanent Partial Disability Compensation

436-060-0040 (1) If a claim is reopened as a result of an aggravation of the worker's condition and temporary disability is due, any permanent partial disability benefits due shall continue to be paid concurrently with temporary disability benefits.

(2) The insurer shall stop temporary disability compensation payments and resume any award payments suspended pursuant to ORS 656.268(9) upon the worker's completion or 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.

Stat. Auth: ORS 656.268(9), ORS 656.704 and ORS 656.726(3)
Stat. Impltd: ORS 656.268(9), ORS 656.704 and ORS 656.726(3)
Hist: Filed 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 436-54-232, 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 (Temp)
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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Payment of Compensation During Worker Incarceration

436-060-0045 (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, ORS 656.704 and ORS 656.726(3)
Stat. Implt: ORS 656.160, ORS 656.704 and ORS 656.726(3)
Hist: Filed 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temp)
Amended 9/18/90 as WCD Admin. Order 19-1990, eff. 9/18/90 (Temp)
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

436-060-0050

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

Payment of Medical Services on Nondisabling Claims; Employer/Insurer Responsibility

436-060-0055 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 436-060-0200(6).

(7) Self-insured employers shall maintain records of all amounts paid for medical services on nondisabling claims in accordance with OAR 436-050-0220. When reporting loss data for experience

rating, the self-insured may exclude costs for medical services paid on nondisabling claims in amounts not to exceed $500 per claim.

Stat. Auth: ORS 656.262(5), ORS 656.704, ORS 656.726(3) and ORS 656.745
Stat. Impltd: ORS 656.262(5), ORS 656.704 and ORS 656.726(3)
Hist: Filed 12/18/87 as WCD Admin. Order 10-1987, eff. 1/1/88 (Temp) 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

436-060-0060 (1) Pursuant to ORS 656.230, in all cases where an award for permanent partial disability does not exceed $6,000, the insurer shall pay all of the award to the worker in a lump sum. When the award for permanent partial disability exceeds $6,000, the insurer or Director may approve an application of the worker for lump sum payment when the order has become final by operation of law or the worker has waived their right to appeal the adequacy of the award. The lump sum application shall be in the form and format prescribed by the Director.

(2) 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. Additional award of permanent partial disability obtained through the appeal process is considered part of the total cumulative award for the open period of that claim.

(3) If the insurer agrees with the worker's request for lump sum payment of a permanent partial disability award in excess of $6,000, they shall make the lump sum payment within 14 days of receipt of the signed application.

(4) If the insurer disagrees with the worker's request for lump sum payment of a permanent partial disability award in excess of $6,000, the insurer must submit the lump sum application with the reason for disagreement to the Director within 14 days of receipt of the signed application. The insurer shall simultaneously inform the worker and the worker's attorney, if represented, of the disagreement and submission to the Division.

(5) The insurer or the Division shall not approve an application for lump sum payment when the worker:

(a) has been found eligible for a vocational training program and will start the program within 30 days of the date of the decision on the lump sum request;

(b) is actively enrolled and engaged in a vocational training program under OAR 436-120;

(c) has temporarily withdrawn from such a program; or

(d) the worker is involved in litigation affecting the permanent partial disability award.

(6) When the Division approves a disputed application, the insurer shall pay the lump sum amount to the worker within 14 days after the mailing of the order.

(7) If any party disagrees with the decision of the Division, the party may petition the Director to reconsider the decision within 14 days after the mailing of the decision. The Director's decision shall be final and not subject to review.

(8) A lump sum payment ordered in a litigation order or which is a part of a Claim Disposition Agreement pursuant to ORS 656.236 does not require further approval by the insurer or the Division.

(9) When a partial payment is approved by the insurer or the Division, it shall be in addition to the regularly scheduled monthly payment. The remaining balance shall be paid pursuant to ORS 656.216. Denial or partial 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 information is submitted.

Stat. Auth: ORS 656.704 and ORS 656.726(3)
Stat. Impltd: ORS 656.230, ORS 656.704 and ORS 656.726(3)
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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Payments to Aliens Residing Outside of United States

436-060-0065

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

436-060-0070 (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. If there is a claim for aggravation or a new medical condition on an accepted claim, reimbursement of related services are not due and payable until the aggravation or new medical condition is accepted.

(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 of related services costs must be received by the insurer within two years of the date the costs were incurred or within two years of the date the claim or medical condition is finally determined compensable, whichever date is later. The insurer may disapprove requests for reimbursement received beyond the two year period as being untimely requested.

(4) 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, ORS 656.704 and ORS 656.726(3)
Stat. Implted: ORS 656.245, ORS 656.704 and ORS 656.726(3)
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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Consent to Suspension of Compensation or Reduction of Benefits Awarded the Worker

436-060-0080

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

Suspension of Compensation and Reduction of Benefits

436-060-0085

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

436-060-0090

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

Medical Examinations; Suspension of Compensation and Notice to Worker

436-060-0095 (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 436-010-0100. 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 436-010. 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 436-060-0095(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 436-060."

(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 436-060-0095;

(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, 350 Winter Street NE, Salem, Oregon 97310. Your letter must be mailed 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, 350 Winter Street NE, Salem, Oregon 97310. Your letter must be mailed within 10 days of the date 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) Notwithstanding the requirements for examinations scheduled pursuant to OAR 436-030-0165, 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, ORS 656.704 and ORS 656.726(3)
Stat. Implted: ORS 656.325, ORS 656.704 and ORS 656.726(3)
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 (Temp)
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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Request for Consent to Suspension of Compensation; Worker's Failure to Participate in a Program at a Physical Rehabilitation Center

436-060-0100

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

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

436-060-0105 (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 workers' compensation benefits. In addition, you may also have any permanent disability award reduced in accordance with ORS 656.325 and OAR 436-060."

(3) 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 436-060-0105;

(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, 350 Winter Street NE, Salem, Oregon 97310. Your letter must be mailed 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, ORS 656.704 and ORS 656.726(3)
Stat. Impltd: ORS 656.325, ORS 656.704 and ORS 656.726(3)
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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Request for Consent to Suspension of Compensation; Worker's Commission of Insanitary or Injurious Practices

436-060-0110

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

436-060-0120

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

436-060-0130

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

Injured Worker, Worker Representative Responsible to Assist in Investigation; Suspension of Compensation and Notice to Worker

436-060-0135 (1) When the worker refuses or fails to cooperate in an investigation of an initial claim for compensation, a claim for a new medical condition, or an aggravation claim as required by ORS 656.262(14), the Division will suspend compensation pursuant to ORS 656.262(15) by order under conditions set forth in this rule. The Division may determine whether special circumstances exist that would not warrant suspension of compensation for failure to cooperate with an investigation. The worker shall have the opportunity to submit information disputing the insurer's request for suspension of compensation prior to issuance of the order.

(2) A worker shall submit to and fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques reasonably requested by the insurer. For the purposes of this rule, "personal and telephonic interviews" may be audio or video taped by one or more of the parties if prior written notice is given of the intent to record or tape an interview.

(3) The Division will consider requests for suspension of benefits pursuant to ORS 656.262(15) only after the insurer has notified the injured worker in writing of the worker's obligation to cooperate as required by section (4) or (5) of this rule and only in claims where there has been no acceptance or denial issued.

(4) For suspension of benefits to be granted under this rule, the insurer shall notify the worker in writing that an interview or deposition has been scheduled, or of other investigation requirements, and shall give the worker at least 14 days to cooperate. The notice shall be sent to the worker and the worker's attorney, if represented, and shall advise the worker of the date, time and place of the interview and/or any other reasonable investigation requirements. The notice shall also contain the following statement in prominent or bold face type:

> **"The workers' compensation law requires injured workers to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers are required to submit to and fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. If you fail to reasonably cooperate with the investigation of this claim, payment of your compensation benefits may be suspended and your claim may be denied in accordance with ORS 656.262 and OAR 436-060."**

(5) Notwithstanding section (4) of this rule, for suspension of benefits to be granted under ORS 656.262(15) for noncooperation during an investigation of a claim resulting from a worker's failure to attend an insurer medical examination, the notification requirements in OAR 436-060-0095(5) must be met; however, the notice required by 436-060-0095(5)(h) must be replaced with the following notice, in prominent or bold face type:

> **"The workers' compensation law requires injured workers to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Therefore, 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, and do not have a good reason for not attending, payment of your compensation benefits may be suspended and your claim may be denied in accordance with ORS 656.262 and OAR 436-060."**

(6) 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. The request shall include the following information sufficient to make a prima facie showing of the worker's failure to cooperate:

(a) That the insurer requests suspension of benefits pursuant to ORS 656.262(15) and this rule;

(b) Documentation of the specific actions of the worker or worker's representative that prompted the request;

(c) Any reasons given by the worker for failure to comply, or a statement that the worker has not given any reasons, whichever is appropriate; and

(d) A copy of the notice required in section (4) or (5) of this rule.

(7) After receiving the insurer's request as required in section (6) of this rule, the Division will promptly notify all parties that the worker's benefits will be suspended in five working days unless the worker or the worker's attorney contacts the Division by telephone or mails a letter documenting that the failure to cooperate was reasonable or unless the insurer notifies the Division that the worker is now cooperating. The notice of the Division will also advise that the insurer's obligation to accept or deny the claim within 90 days is suspended unless the insurer's request is filed with the Division after the 90 days to accept or deny the claim has expired.

(8) If the worker has not documented that the failure to cooperate was reasonable, the Division will issue an order suspending all or part of the payment of compensation to the worker. The suspension will be effective the fifth working day after notice is provided by the Division as required by section (7) of this rule. The suspension of compensation shall remain in effect until the worker cooperates with the investigation. If the worker makes no effort to reinstate compensation within 30 days of the date of the notice, the insurer may deny the claim.

(9) If the worker documents that the failure to cooperate was reasonable the Division will not suspend payment of compensation. However, an order will be issued suspending the 90 days to accept or deny the claim from the filing date of the insurer's complaint to the date of the order as long as the insurer initially made a prima facie showing that the worker was noncooperative.

(10) Pursuant to ORS 656.262(14), an insurer who believes that a worker's attorney's unwillingness or unavailability to participate in an interview is unreasonable may notify the Director in writing and the Division will consider assessment of a civil penalty against the attorney of not more than $1,000. The worker's attorney shall have the opportunity to dispute the allegation prior to the issuance of a penalty. Notice under this section shall be sent to the Division. A copy of the notice shall be sent simultaneously to the worker and the worker's attorney. Notice to the Division by the insurer shall contain the following information:

(a) What specific actions of the attorney prompted the request;

(b) Any reasons given by the attorney for failing to participate in the interview; and

(c) A copy of the request for interview sent to the attorney.

(11) Failure to comply with the requirements of this rule will be grounds for denial of the insurer's request.

Stat. Auth: ORS 656.704 and ORS 656.726(3)
Stat. Impltd: ORS 656.262(14) and (15), ORS 656.704, and ORS 656.726(3)
Hist: Filed 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96
Amended 8/5/96 as WCD Admin. Order 96-066, eff. 8/12/96 (Temp)
Amended 10/18/96 as WCD Admin. Order 96-070, eff. 11/27/96

Acceptance or Denial of a Claim

436-060-0140 (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(6)(b) and the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law, OAR Chapter 438. 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.

(g) That if the worker believes a condition has been incorrectly omitted from the notice of acceptance, or the notice is otherwise deficient, the worker must first communicate the objection to the insurer in writing specifying either that the worker believes the condition has been incorrectly omitted or why the worker feels the notice is otherwise deficient.

(6) A claim for a new medical condition must clearly identify the condition as a new medical condition and must request formal written acceptance of the condition.

(7) The notice of denial shall comply with the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law, OAR Chapter 438, 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.

(8) 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.

(9) 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.

(10) 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 656.704 and ORS 656.726(3)
Stat. Implted: ORS 656.262(6), ORS 656.704, and ORS 656.726(3)
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 (Temp)
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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96
Amended 8/5/96 as WCD Admin. Order 96-066, eff. 8/12/96 (Temp)
Amended 10/18/96 as WCD Admin. Order 96-070, eff. 11/27/96

Disposition of a Claim

436-060-0145

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 (Temp)
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 (Temp)
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
Repealed 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Timely Payment of Compensation

436-060-0150 (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 pursuant to ORS 187.010 and ORS 187.020 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 weekend or legal holiday.

(2) For the purpose of this rule, legal holidays in the State of Oregon are:

(a) Each Sunday;

(b) New Year's Day on January 1;

(c) Martin Luther King, Jr.'s Birthday on the third Monday in January;

(d) Presidents Day, for the purpose of commemorating Presidents Washington and Lincoln, on the third Monday in February;

(e) Memorial Day on the last Monday in May;

(f) Independence Day on July 4;

(g) Labor Day on the first Monday in September;

(h) Veterans Day on November 11;

(i) Thanksgiving Day on the fourth Thursday in November; and

(j) Christmas Day on December 25.

(k) Each time a holiday, other than Sunday, falls on Sunday, the succeeding Monday shall be a legal holiday. Each time a holiday falls on Saturday, the preceding Friday shall be a legal holiday.

(l) Additional legal holidays shall include every day appointed by the Governor as a legal holiday and every day appointed by the President of the United States as a day of mourning, rejoicing or other special observance only when the Governor also appoints that day as a holiday.

(3) 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.

(4) Compensation withheld pursuant to ORS 656.268(14) and (15), and ORS 656.596(2) shall not be deemed untimely provided the insurer notifies the worker in writing why benefits are being withheld and the amount that must be offset before any further benefits are payable.

(5) Timely 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 and the attending physician has authorized the temporary disability;

(b) The insurer's receipt of authorized temporary disability when the temporary disability is not immediate or there has been an interruption in the payment schedule;

(c) The start of vocational training pursuant to ORS 656.268(9), 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 a reconsideration order has been appealed by the insurer, the appeal stays payment of temporary disability benefits except those which accrue from the date of the order, pursuant to ORS 656.313;

(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 filed;

(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 an assigned claims agent pursuant to ORS 656.054; 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.

(6) Temporary disability shall be paid to within seven days of the date of payment at least once each 14 days. When making payments as provided in OAR 436-060-0020(1), the employer may make subsequent payments of temporary disability concurrently with the payroll schedule of the employer, rather than at 14-day intervals.

(7) 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 or fatal benefits;

(c) The date of any department order which orders payment of compensation for permanent partial disability. A request for reconsideration of a determination order does not stay payment of permanent partial disability compensation 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.

(8) Subsequent payments of permanent disability and fatal benefits are made in monthly sequence. 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.

(9) 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.

(10) Payment of a Claims Disposition Agreement shall be made no later than the 14th day after the Board mails notice of its approval of the agreement to the parties, unless otherwise stated in the agreement.

(11) Pursuant to ORS 656.126(6), when Oregon compensation is more than the compensation under another law for the same injury or occupational disease, or compensation paid the worker under another law is recovered from the worker for the same injury or occupational disease, the insurer shall

pay any unpaid compensation to the worker up to the amount required by the claim under Oregon law within 14 days of receipt of written documentation supporting the underpayment of Oregon compensation.

Stat. Auth: ORS 656.704 and ORS 656.726(3)
Stat. Impltd: ORS 656.262(4), ORS 656.268(9), ORS 656.273, ORS 656.278, ORS 656.289, ORS 656.307, ORS 656.313, ORS 656.704 and ORS 656.726(3)
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 (Temp)
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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Penalty to Worker for Untimely Processing

436-060-0155 (1) Pursuant to ORS 656.262(11), 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 436-010.

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

(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 mailed or delivered to 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 mailed or delivered to the Director within 180 days of the date of the last underpayment. All prior underpayments will be considered as one violation, regardless of when the first underpayment occurred.

(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 mailed or delivered to the Division within 21 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 436-060-0200. 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 436-060-0200.

(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 436-060-0200.

(6) The Director will only consider a penalty issue where the assessment and payment of additional amounts described in ORS 656.262(11) 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 436-060-0200.

(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(11) 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 436-060-0200.

(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(11), ORS 656.704, ORS 656.726(3) and ORS 656.745
Stat. Impltd: ORS 656.262(11), ORS 656.704 and ORS 656.726(3)
Hist: Filed 6/18/90 as WCD Admin. Order 8-1990, eff. 7/1/90 (Temp)
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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Use of Sight Draft to Pay Compensation Prohibited

436-060-0160 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 656.704 and ORS 656.726(3)
Stat. Impltd: ORS 656.704 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 436-54-315, 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

436-060-0170 (1) Insurers may recover overpayment of benefits paid to a worker as specified by ORS 656.268(13) and (15), unless authority is granted by an Administrative Law Judge or the Workers' Compensation Board.

(2) Insurers may recover an overpayment from any benefits currently due on any claim the

worker has with that insurer. 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.

(3) When overpaid benefits are offset against monthly permanent partial disability award payments, the recovery shall be from the total amount of the award with the remainder of the award being paid out at 4.35 times the temporary total disability rate and no less than $108.75, starting with the first month's payment.

Stat. Auth: ORS 656.704 and ORS 656.726(3)
Stat. Impltd: ORS 656.268(13) and (15), ORS 656.704 and ORS 656.726(3)
Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff 1/11/80
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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 (Temp)
Amended 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Designation and Responsibility of a Paying Agent

436-060-0180 (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 one or more on-the-job injuries and/or occupational diseases; 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. For the purposes of this rule, insurers identified in a potential responsibility dispute pursuant to ORS 656.307 shall, upon request, share claim related medical reports and other information pertinent to the injury in order to expedite claim processing. The act of the worker applying for compensation benefits from any employer identified as a party to a responsibility dispute shall constitute authorization for the involved insurers to share the pertinent information in accordance with the criteria and restrictions provided in OAR 436-060-0017 and OAR 436-010-0030.

No insurer who shares information in accordance with this rule shall bear any legal liability for disclosure of such information.

(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 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) 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.

(7) 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 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.

(8) 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 21 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 436-060-0200.

(9) 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 (6).

(10) 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.

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

(12) The designated paying agent shall process the claim as an accepted claim through determination unless relieved of the responsibility by an order of the Administrative Law Judge or resolution through mediation or arbitration pursuant to ORS 656.307(6). The parties to an order under this section shall not settle any part of a claim pursuant to ORS 656.236 or ORS 656.289, except to resolve the issue of responsibility, unless prior approval and agreement is obtained from all potential responsible insurers. Resolution of a dispute by mediation or arbitration by a private party cannot obligate the Consumer and Business Services Fund without the prior approval of the Director. 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, ORS 656.704, ORS 656.726(3) and ORS 656.745
Stat. Implted: ORS 656.307, ORS 656.308, ORS 656.704 and ORS 656.726(3)
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 (Temp).
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 (Temp)
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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Arbitration Proceedings Costs Allocation

436-060-0185

Stat. Auth: ORS 656.307
Hist: Filed 12/18/87 as WCD Admin. Order 10-1987, eff. 1/1/88 (Temp) 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
Repealed 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Monetary Adjustments Among Parties and Department of Consumer and Business Services

436-060-0190 (1) An order of the Director pursuant to ORS 656.307 and OAR 436-060-0180 applies only to the period prior to the order of the Administrative Law Judge 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 Administrative Law Judge's order was received by the paying agent designated under OAR 436-060-0180. Any monetary adjustment necessary after the Administrative Law Judge's order shall be handled under OAR 436-060-0195.

(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 Administrative Law Judge 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 436-060-0200. Only compensation paid as a result of an order by the Director pursuant to OAR 436-060-0180 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.

Stat. Auth: ORS 656.704 and ORS 656.726(3)
Stat. Impltd: ORS 656.307(3), ORS 656.704 and ORS 656.726(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
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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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

Miscellaneous Monetary Adjustments Among Insurers

436-060-0195 (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 436-060-0190. Any failure to obtain reimbursement from an insurer under this rule shall not be recoverable from the Consumer and Business Services Fund. The purpose of this rule is to ensure the claimant properly receives all compensation due under the workers' compensation law, but is not unduly compensated for more than the law intended.

(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 436-060-0200.

(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 656.704, ORS 656.726(3) and ORS 656.745
Stat. Impltd: ORS 656.704 and ORS 656.726(3)
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

436-060-0200 (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 436-060-0010, 436-060-0017, 436-060-0030, 436-060-0060, 436-060-0070, 436-060-0155 and 436-060-0180 may be assessed a civil penalty up to $1,000.

(4) An insurer who willfully violates OAR 436-060-0160 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".

(11) Pursuant to ORS 656.262(14), an injured worker's attorney that is not willing or available to participate in an interview at a time reasonably chosen by the insurer within 14 days of the request for interview may be assessed a civil penalty not to exceed $1,000 if the Director finds the attorney's actions unreasonable.

Stat. Auth.: ORS 656.704 and ORS 656.726(3)
Stat. Implted: 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, ORS 656.704, 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 436-54-981, 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 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
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96
Amended 10/18/96 as WCD Admin. Order 96-070, eff. 11/27/96

Issuance/Service of Penalty Orders

436-060-0210 (1) When a penalty is assessed as provided by OAR 436-060-0200, 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 656.704 and ORS 656.726(3)
Stat. Implted: ORS 656.704, ORS 656.726(3) and ORS 656.740
Hist: Filed 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 436-54-983, 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 8/11/94 as WCD Admin. Order 94-055, eff. 8/28/94

Suspension and Revocation of Authorization to Issue Guaranty Contracts

436-060-0220 (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 the Division, the administrator may request the Director to lift the suspension before the 18 months has elapsed. If the insurer is not in the Division, 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 436-060-0008.

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

Stat. Auth: ORS 656.704 and ORS 656.726(3)
Stat. Implt d: ORS 656.447, ORS 656.704 and ORS 656.726(3)
Hist: Filed 11/30/90 as WCD Admin. Order 26-1990, eff. 12/26/90
Amended 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96

APPENDIX "A"

436-060-0017 Matrix for Assessing Penalties

	VIOLATION NUMBER				
NUMBER OF DAYS	1.00	2.00	3.00	4.00	5+
LATE					
1-7	$0	$100	$250	$500	$1,000
8-14	$100	$250	$500	$1,000	$1,000
15-21	$250	$500	$1,000	$1,000	$1,000
22+	$500	$1,000	$1,000	$1,000	$1,000

APPENDIX "B"

436-060-0155 Matrix for Assessing Penalties

	VIOLATION NUMBER			
NUMBER OF DAYS	1.00	2.00	3.00	4.00
LATE				
1-2	0%	10%	20%	25%
3-7	5%	15%	25%	
8-14	10%	20%	25%	
15-21	15%	25%		
22 +	25%			

APPENDIX "C"

436-060-0200 Matrix for Assessing Penalties

	Number of Quarters below Standard Performance Level Per Year			
CATEGORY	1	2	3	4
Timely Filing of Claim (Form 1502)	$50 each violation $250 Max	$100 each violation $500 Max	$150 each violation $750 Max	$200 each violation $1000 Max
Request for Closure Submitted Timely (Form 1503)	$50 each violation $250 Max	$100 each violation $500 Max	$150 each violation $750 Max	$200 each violation $1000 Max
Notice of Closure Issued 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

EXHIBIT "B"
STATEMENT OF NEED AND FISCAL IMPACT
BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON

Chapter 436-060

In the matter of proposed rule making regarding:	)	Statutory Authority, Statement of Need
	)	Principal Documents Relied Upon and
OAR 436-060-0003, 0020, 0025, 0030, 0135,	)	Statement of Fiscal Impact
0140, 0160, 0200 and Appendix "C"	)	
Claims Administration	)	
	)	

1. Citation of statutory authority: ORS 656.210, ORS 656.212, ORS 656.230, ORS 656.245, ORS 656.262, ORS 656.264, ORS 656.265, ORS 656.268, ORS 656.307, ORS 656.325, ORS 656.331, ORS 656.704 and ORS 656.726(3)

2. Need for the rules: Department and industry staff are unable to award time loss benefits at the time of closure in claims where authorized time loss is not documented but files indicate periods of time that would reasonably be expected to result in compensable disability. These rules clarify that authorization of time loss is to be documented and that certain circumstances may be construed as authorization if supported by contemporaneous reports. These rules also make this provision fully retroactive.

   OAR 436-060-0135 conflicts with the Workers' Compensation Board's administration of litigated claims which are in a denied status. Public input and staff analysis strongly suggests that suspension of benefits for claimant's non-cooperation after the claim has been denied is in conflict with the law.

   Confusion exists about whether or not claimants must submit to taped interviews.

   Additional notification requirements are necessary to injured workers when insurers are requesting their benefits be suspended for non-cooperation because the injured worker has refused to attend an insurer medical examination.

   OAR 436-060-0140 does not currently require claimants to identify whether the conditions that they want accepted are conditions which were omitted from an acceptance notice, new conditions that have been identified or aggravation of a existing condition.

   General housekeeping for clarification.

3. Documents Relied Upon: ORS Chapter 656, public comment, input from the Department of Justice, "Protective Orders" issued by the Workers' Compensation Board's Hearing Division.

4. Fiscal and economic Impact The Department has identified that these rules have an economic impact on: Oregon subject workers; Oregon subject employers; and Workers' Compensation insurers, self-insured employers, and service companies. The amount of the impact cannot be quantified based on available data.

5. Advisory Committee Used: The Department held an Advisory Committee meeting on August 6, 1996

Dated this _14th_ day of August, 1996.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

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Kerry Barnett, Director