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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 120

VOCATIONAL ASSISTANCE TO INJURED WORKERS

TABLE OF CONTENTS

EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 120

436-120-0001 Authority for Rules

The director has adopted OAR 436-120 by the director's authority under ORS 656.283(2), ORS 656.340, ORS 656.726(3) and section 15, chapter 600, Oregon Laws 1985.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.262(6); ORS 656.268; ORS 656.283(2); ORS 656.313; ORS 656.331(1)(b); ORS 656.340; ORS 656.447; ORS 656.740; ORS 656.745; ORS chapt. 183; Section 15, chapt. 600, Oregon Laws 1985
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Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95

436-120-0002 Purpose of Rules

The purpose of these rules is to prescribe:

(1) The terms of eligibility for vocational assistance to workers with disabling compensable injuries, and the nature and extent of the assistance, pursuant to ORS 656.012(2)(c), 656.268(1) and 656.340;

(2) The standards, conditions and procedures for authorizing insurers and vocational rehabilitation organizations to be providers of vocational assistance; for certifying vocational assistance staff; and for suspending and revoking authorizations and certifications, pursuant to ORS 656.340;

(3) Fee schedules and conditions for payment by insurers for vocational assistance provider services and direct worker purchases, pursuant to ORS 656.258 and 656.340;

(4) Recordkeeping and reporting requirements for insurers to assist the department in monitoring their compliance with ORS 656.340;

(5) Procedures for resolving dissatisfaction about vocational assistance actions, including procedures for the administrative review by the director under ORS 656.283;

(6) The terms of reimbursement to insurers for vocational assistance costs paid for injuries sustained prior to January 1, 1986, pursuant to section 15, chapter 600, Oregon Laws 1985; and

(7) The penalties for noncompliance with ORS chapter 656.283 and 656.340 and these rules.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.012(2)(c); ORS 656.258; ORS 656.268(1); ORS 656.283; ORS 656.340; Section 15, chapt. 600, Oregon

Laws 1985
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Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95

436-120-0003 Applicability of Rules

(1) These rules govern vocational assistance pursuant to the Workers' Compensation Law on or after March 1, 1996, except as these rules provide otherwise.

(2) These rules also govern administrative review and contested case processes, as described in OAR 436-120-0008, for all disputes under the jurisdiction of the director on or after March 1, 1996. The director's decisions under OAR 436-120-0008(1) regarding eligibility will be based on the rules in effect on the date the insurer issued the notice. The director's decisions regarding the nature and extent of assistance will be based on the rules in effect at the time the assistance was provided. If the director orders future assistance, such assistance shall be provided in accordance with these rules.

(3) Under these rules a claim for aggravation will be considered a new claim for purposes of vocational assistance eligibility and vocational assistance, except as otherwise provided in these rules. A reference to "pre-1986 injuries" relates to injuries sustained before January 1, 1986, and encompasses both original claims and claims for aggravation of such injuries. Board's Own Motion or a voluntary reopening after the expiration of a worker's aggravation rights is not a claim for aggravation and does not constitute a reopening of the claim for vocational assistance eligibility purposes.

(4) Vocational assistance will be due at any given time with respect only to one claim of the worker. If the worker is eligible for vocational assistance under two or more claims, and there is a dispute about which claim gives rise to the need for vocational assistance pursuant to these rules, the director will select the claim for the injury with the greatest number of degrees of permanent disability. If one or more of the claims are open at the time of this selection, the director will choose the claim for the injury which results in the most severe vocational impact. In assessing vocational impact, the director will consider factors which include, but are not limited to, the worker's injury-related limitations, education, work history, and labor market.

(5) The insurer must authorize any vocational assistance provided under these rules. Claim disposition agreement negotiations shall not be cause for staying determination of eligibility or provision of vocational assistance, unless the insurer and the worker or worker's representative agree in writing to such a stay. Appeal of a decision by the insurer shall be made pursuant to ORS 656.283 and OAR 436-120-0008(1).

(6) The director may modify or waive provisions of OAR 436-120-0330(4); OAR 436-120-0440(2), (3), and (5); OAR 436-120-0450(1) and (2); and OAR 436-120-0720 if the director finds that necessary to carry out the provisions and intent of ORS chapter 656.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.283(2), ORS 656.340
Hist: Filed 3/29/76 as WCD Admin. Order 1-1976, eff. 4/1/76
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Amended 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
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Amended 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as Admin. Order 95-074, eff. 3/1/96

436-120-0004 Objectives and Priorities of Vocational Assistance

(1) The objective of vocational assistance is to return the worker to employment which is as close as possible to the worker's regular employment at a suitable wage as defined in OAR 436-120-0005(12)(b).

(2) For workers determined eligible for vocational assistance under these rules, insurers are required to select the appropriate category of assistance necessary to accomplish the objective described in section (1) of this rule. Selection of the category of assistance most likely to return the worker to suitable employment shall be made in accordance with OAR 436-120-0400. The priorities to be considered in selecting the appropriate assistance are, in order:

(a) Return to suitable employment with the employer at injury if that opportunity arises after the worker has been found eligible under OAR 436-120-0330 and 0340.

(b) Return to suitable employment with a new employer using direct employment services.

(c) Return to suitable employment using training services.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.340(5), ORS 656.340(7)
Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin Order 95-074, eff. 3/1/96

436-120-0005 Definitions

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

(1) "Administrative approval" means an approval or finding in a particular matter by the administrator of the Workers' Compensation Division, or the administrator's delegate.

(2) "Cost-of-living matrix" is a chart issued annually by the director which establishes factors used to adjust for changes in the cost of living based on percentage increases or decreases in the maximum temporary total disability rate.

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

(4) "Employer at injury" means a subject employer, pursuant to ORS chapter 656, in whose employ the worker sustained the disabling compensable injury.

(5) "Insurer" means the State Accident Insurance Fund, an insurer authorized under ORS

chapter 731 to transact workers' compensation insurance in Oregon, or a self-insured employer. It also may include, except where the context requires otherwise, a vocational assistance provider acting as the insurer's delegate. "The insurer" refers to whichever insurer has the worker's claim.

(6) "Nonconforming plan" means a plan for an eligible worker which does not meet the minimum standards required by these rules.

(7) "Permanent job" means a job which at the time of hire was, or is currently expected to continue indefinitely with no projected end date. A permanent job may be year-round or seasonal.

(8) "Regular employment" means the employment the worker held at the time of the injury or claim for aggravation, whichever gave rise to the potential eligibility for vocational assistance; or, for a worker not employed at the time of aggravation, the employment the worker held on the last day of work prior to the aggravation.

(9) "Return-to-work plan" means either the vocational assistance program, or the document which establishes and governs that program. A return-to-work plan may be either a "direct employment plan" or a "training plan."

(10) "Substantial handicap to employment," for the purposes of determining eligibility for vocational assistance, means the worker, because of the injury or aggravation, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in suitable employment. "Knowledge," "skills," and "abilities" have meanings as follows:

(a) "Knowledge" means an organized body of factual or procedural information derived from the worker's education, training and experience.

(b) "Skills" means the demonstrated mental and physical proficiency to apply knowledge.

(c) "Abilities" means the mental and physical capability to apply the worker's knowledge and skills.

(11) "Suitable employment" or "suitable job" means employment or a job:

(a) For which the worker has the necessary physical capacities, knowledge, skills and abilities;

(b) Located where the worker customarily worked, or within reasonable commuting distance of the worker's residence; and,

(c) Which pays or would average on a year-round basis a suitable wage as defined in section (12) of this rule; and,

(d) Which is permanent. Temporary work is suitable if the worker's job at injury was temporary; and the worker has transferable skills to earn, on a year-round basis, a suitable wage as defined in section (12) of this rule.

(12) "Suitable wage" means:

(a) For the purpose of determining eligibility for vocational assistance, a wage at least 80 percent of the adjusted weekly wage calculated as described in OAR 436-120-0310.

(b) For the purpose of providing and/or ending vocational assistance, a wage as close as

possible to 100 percent of the adjusted weekly wage calculated as described in OAR 436-120-0310. This wage may be considered suitable if less than 80 percent of the adjusted weekly wage, if the wage is as close as possible to the adjusted weekly wage.

(13) "Transferable skills" means the knowledge and skills demonstrated in past training or employment which make a worker employable in suitable new employment. More general characteristics such as aptitudes or interests do not, by themselves, constitute transferable skills.

(14) "Vocational assistance" means any of the services, goods, allowances and temporary disability compensation under these rules for assisting in the return to work of an eligible injured worker. The term does not include activities for determining a worker's eligibility for vocational assistance.

(15) "Vocational assistance provider" means an insurer or other public or private organization authorized under these rules to provide vocational assistance to injured workers.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.340
Hist: Filed 6/30/66 as WCD Admin. Order 7-1966, eff. 6/30/66
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Amended 3/29/76 as WCD Admin. Order 1-1976, eff. 4/1/76
Amended 9/29/77 as WCD Admin. Order 3-1977, eff. 10/4/77 (Temporary)
Amended 2/1/78 as WCD Admin. Order 1-1978, eff. 2/1/78
Amended 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
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Amended 2/2/96 as WCD Admin Order 95-074, eff. 3/1/96
Amended 12/11/96 as WCD Admin Order 96-073, eff. 2/1/97

436-120-0006 Administration of Rules

(1) At any time, the director may order the insurer to determine eligibility or provide specified vocational assistance to achieve compliance with ORS chapter 656 and these rules. The order may be appealed as provided by statute.

(2) Orders issued by the division to enforce ORS 656 and these rules are considered orders of the director.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.283(2), ORS 656.313
Hist: Amended and Renumbered from OAR 436-120-001 and 210, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin Order 95-074, eff. 3/1/96

436-120-0008 Administrative Review and Contested Cases

(1) **Administrative review of vocational assistance matters**: Under ORS 656.283(2) and ORS 656.340(4), a worker wanting review of a vocational assistance matter, including disagreement about the selection of a vocational assistance provider, must first apply to the director for administrative review. Also, under ORS 656.340(11) and OAR 436-120-0380(3) when the worker and insurer are unable to agree on a vocational assistance provider, the insurer

shall apply to the director for administrative review. Because effective vocational assistance is best realized in a nonadversarial environment, the first objective of the administrative review is to bring the parties to resolution through alternative dispute resolution procedures whenever possible and appropriate. When a dispute is not resolved through mutual agreement or dismissal, the director shall close the record and issue a Director's Review and Order as described in subsections (f) and (g). A worker need not be represented to request or to participate in the administrative review process, which is as follows:

(a) The worker's request must be mailed to the department no later than the 60th day after the date the worker received written notice of the insurer's action; or, if the worker was represented at the time of the notice, within 60 days of the date the worker's representative received actual notice. Appeals from notices issued prior to January 1, 1988, must be made no later than May 1, 1996. Issues raised by the worker where written notice was not provided may be reviewed at the director's discretion.

(b) The worker, insurer, employer at injury, and provider shall supply needed information, attend mediation conferences and meetings, and participate in the administrative review process as required by the director. Upon the director's request, any party to the dispute shall provide available information within 14 days of the request. The insurer shall promptly schedule, pay for, and submit to the director any medical or vocational tests, consultations, or reports required by the director. The worker, insurer, employer at injury, or provider shall simultaneously send copies to the other parties to the dispute when sending material to the director. If necessary, the director will assist an unrepresented worker in sending copies to the appropriate parties. Failure to comply with this subsection may result in the following:

(A) If the worker fails to comply without good cause, the director may dismiss the administrative review as described in subsection (d); or, if there is adequate information upon which to make a decision, the director may decide the issue on the basis of available information.

(B) If the insurer fails to comply without good cause, the director may penalize or sanction the insurer under OAR 436-120-0900, or as otherwise provided by statute, and may decide the issue on the basis of available information.

(C) If the provider fails to comply without good cause, the director may sanction the provider under OAR 436-120-0850, or as otherwise provided by statute.

(D) If the employer at injury fails to comply without good cause, the director may sanction the employer under OAR 436-120-0900, or as otherwise provided by statute.

(c) At the director's discretion, the director may issue an order of deferral under the circumstances described in paragraphs (A) through (D) of this subsection. The director will determine the conditions under which the review will be resumed, and will so specify in the deferral.

(A) Claim disposition agreement negotiations are in progress and the parties agree to defer the review pending the outcome of the negotiations; or

(B) The record cannot be completed because necessary information is not and will not be available for a prolonged period of time. Examples of such information include, but are not limited to, medical information to be derived from future examinations or physical capacities

evaluations, or results of a scheduled hearing regarding wage at injury or compensability of a denied condition; or

(C) The worker is unable to participate in the administrative review process because of personal or medical problems, or the issue is premature for review; or

(D) The director determines, on the motion of a party or otherwise, that a deferral will further substantial justice.

(d) The director may issue an order of dismissal with prejudice, which does not allow reconsideration of the issue at a later date, under appropriate conditions, including the following:

(A) The worker fails to participate or to provide information under paragraph (1)(b)(A) of this rule. The worker may appeal the dismissal under OAR 436-120-0008(2); or

(B) The worker withdraws the request for review. The worker may appeal the dismissal under OAR 436-120-0008(2); or

(C) The worker disposes of vocational rights through a claim disposition agreement; or

(D) The director determines that the director lacks jurisdictional authority to hear the appeal. The worker may appeal the dismissal under OAR 436-120-0008(3).

(e) The director shall issue a letter of agreement when the parties resolve a dispute within the scope of these rules. The agreement will become final on the tenth day after the letter of agreement is issued unless the director and the parties agree on a different time period. Once the agreement becomes final, the director may reconsider approval of the agreement upon the director's own motion or upon a motion by a party. The director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) One or both parties have failed to honor the agreement;

(B) The agreement was based on misrepresentation; or

(C) Implementation of the agreement is not feasible because of unforeseen circumstances.

(f) After the parties have had the opportunity to present evidence, and any meetings or conferences deemed necessary by the director have been held, the director shall issue a final order, including the notice of record contents. The parties will have 60 days from the issuance of the order to request a contested case hearing before the director.

(g) The director may on the director's own motion reconsider any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new material evidence which could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request for reconsideration must be mailed before the administrative order becomes final, or if appealed, before the contested case order is issued.

(h) During any reconsideration of the administrative review order, the parties may submit new material evidence consistent with this subsection and may respond to such evidence submitted by others.

(i) Any party requesting reconsideration or responding to a reconsideration request shall simultaneously notify all other interested parties of their contentions and provide them with copies of all additional information presented.

(j) A request for reconsideration does not stay the 60 day time period within which the parties must request a contested case hearing. However, at the director's sole discretion, a nonfinal order may be withdrawn.

(2) **Contested cases regarding the director's administrative review**: Under ORS 656.283, orders issued under subsection (1)(g) of this rule and dismissals issued under paragraphs (1)(d)(A) and (B) of this rule may be appealed to the director for a contested case hearing before a Workers' Compensation Division's administrative law judge as follows:

(a) The party must send the request for hearing in writing to the administrator of the Workers' Compensation Division and shall simultaneously send a copy of the request to the other party(ies). The request must specify the grounds upon which the order is contested.

(b) The party must mail the request to the division within 60 days of the order issue date.

(c) The division will conduct the hearing in accordance with the rules governing contested case hearings in OAR 436-0001.

(3) **Contested cases regarding jurisdiction or reimbursement of costs:** Under ORS 183.310 through 183.550 and ORS 656.704(2), a worker may appeal an order of dismissal based on lack of jurisdiction under paragraph (1)(d)(D) of this rule; or, under ORS 183.310 through 183.550 and ORS 656.704(2), an insurer may appeal department denial of reimbursement for vocational assistance costs under OAR 436-120-0730 or of temporary disability compensation costs under OAR 436-120-0750 as follows:

(a) The party must send the request for hearing in writing to the administrator of the Workers' Compensation Division. The party must also simultaneously send a copy of the request to the other party(ies). The request must specify the grounds upon which the denial is contested.

(b) The party must mail the request to the division no later than the 30th day after the party received the dismissal or written denial.

(c) The division will conduct the hearing in accordance with the rules governing contested case hearings in OAR 436-0001.

(4) **Contested case hearings of civil penalties**: Under ORS 656.740 an insurer or an employer may appeal a proposed order or proposed assessment of civil penalty pursuant to ORS 656.745 and OAR 436-120-0900(1) through (4) as follows:

(a) The insurer or employer must send the request for hearing in writing to the department at the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The party must mail the request to the division no later than the 20th day after the insurer or employer received notice of the proposed order or assessment.

(c) The division shall forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(d) The Hearings Division shall conduct the hearing in accordance with ORS 656.740 and ORS Chapter 183.

(5) **Contested case hearings of sanctions and denials of certification or authorization by the director**: Under ORS 183.310 through 183.550, an insurer sanctioned pursuant to ORS 656.447 and OAR 436-120-0900(5), a provider or certified individual sanctioned pursuant to ORS 656.340(9)(b) and OAR 436-120-0850, an insurer denied authorization pursuant to ORS 656.340(9)(a) and OAR 436-120-0800, or an individual denied certification pursuant to ORS 656.340(9)(a) and OAR 436-120-0810 may appeal as follows:

(a) The party must send the request for administrative review in writing to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the action is contested.

(b) The party must mail the request to the division no later than the 60th day after the party received notification of the action, unless the director determines there was good cause for delay or that substantial injustice may otherwise result.

(c) The division will conduct the hearing in accordance with the rules governing contested case hearings in OAR 436-0001.

Stat. Auth.: ORS 656.704(2), ORS 656.726(3)
Stat. Impltd.: ORS 183.310 through 183.555, ORS 656.283(2), ORS 656.340, ORS 656.447 ORS 656.740, ORS 656.745
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Amended 12/11/96 as WCD Admin Order 96-073, eff. 2/1/97

[**ED. NOTE**: Former OAR 436-120-010 through 270 have been amended and renumbered in their entirety.]

436-120-0300 Reinstatement Rights; Responsibilities of Insurer and Worker

(1) The insurer shall inform a worker with a compensable injury of the employment reinstatement rights and responsibilities of the worker under ORS chapter 659 and this rule. This information shall be given:

(a) At the time of claim acceptance, pursuant to ORS 656.262(6);

(b) At the time of contact of the worker under OAR 436-120-0320 about the need for vocational assistance, pursuant to ORS 656.340(2); and

(c) Within five days of receiving knowledge of the attending physician's release of the worker to return to work, pursuant to ORS 656.340(3).

(2) Within five days of receiving notification of the attending physician's release, the insurer shall inform the worker about the opportunity to seek reemployment or reinstatement under ORS 659.415 and 659.420, and inform the employer about the worker's reemployment rights.

Stat. Auth.: ORS 656.726(3)
Stat. Impltd.: ORS 656.262(6), ORS 656.340(2) and (3)
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436-120-0310 Establishing the Adjusted Weekly Wage to Determine Suitable Wage

To determine a suitable wage as defined in OAR 436-120-0005(12)(a) and (b), the insurer shall first establish the adjusted weekly wage as described in this rule. The insurer must calculate the adjusted weekly wage whenever determining or redetermining a worker's eligibility.

(1) For the purposes of this rule, the following definitions apply:

(a) "Adjusted weekly wage" is the wage currently paid as calculated under this rule.

(b) "Cost-of-living adjustments" or "collective bargaining adjustments" are increases or decreases in the wages of all workers performing the same or similar jobs for a specific employer. These adjustments are not variations in wages based on skills, merit, seniority, length of employment, or number of hours worked.

(c) "Cost-of-living matrix," as defined in OAR 436-120-0005(2), establishes the factor by which a worker's weekly wage is multiplied to arrive at the adjusted weekly wage under subsection (9)(c) of this rule. This factor is based on the percentage increase or decrease in the maximum temporary total disability rate from the date of injury to the date of calculation.

(d) "Earned income" means gross wages, salary, tips, commissions, incentive pay, bonuses and the reasonable value of considerations (housing, utilities, food, etc.) from an employer for services performed. Earned income also means gross earnings from self employment after deductions of business expenses excluding depreciation. Earned income does not include fringe benefits such as medical, life or disability insurance, or employer contributions to pension plans; or reimbursement of the worker's employment expenses such as mileage or equipment rental.

(e) "Job at aggravation" or "jobs at aggravation" are the job or jobs the worker held on the date of aggravation; or, for a worker not employed at time of aggravation, the last job or concurrent jobs held prior to the aggravation. Volunteer work does not constitute a job for purposes of this subsection.

(f) "Job at injury" is the job on which the worker originally sustained the compensable injury.

(g) "Permanent, year-round employment" is a job with no projected end date or a job which had no projected end date at time of hire; and on which the worker worked or was scheduled or projected to work in 48 or more calendar weeks a year. Paid leave shall be counted as work time. Permanent year-round employment includes trial service. It does not include employment with an annual salary set by contract or self employment.

(h) "Trial service" is employment designed to lead automatically to permanent, year-round employment subject only to the employee's satisfactory performance during the trial service period.

(2) The insurer shall determine the nature of the job at injury or the job or jobs at aggravation by contacting the employer or employers and obtaining verification of the worker's employment status. The insurer shall calculate the worker's weekly wage using the method described in sections (3), (4), (5), (6), (7) or (8) of this rule, whichever is applicable.

(3) **The job at injury was permanent, year-round employment; employment with an annual salary set by contract; self employment; or volunteer or other covered employment with no wages**:

(a) Use the weekly wage upon which temporary total disability was based; and,

(b) Convert the weekly wage to the adjusted weekly wage as described in section (9) of this rule.

(4) **The job at aggravation was permanent, year-round employment**: Calculate the worker's weekly wage as described in subsections (a) or (b). All figures used in determining a weekly wage by this method shall be supported by verifiable documentation such as payroll records, the worker's state or federal tax returns, or reports of earnings from the Employment Department.

(a) If the worker was scheduled to work the same number of hours every week, use the weekly wage for the last full week the worker worked or was scheduled to work; or

(b) If the number of hours worked per week varied, total the worker's earned income from the job at aggravation for the 52 weeks prior to the aggravation or the last day worked prior to the aggravation, whichever is applicable, and divide the total by the number of calendar weeks in which the worker had earnings from this job during the applicable 52 weeks; and

(c) After arriving at the weekly wage through subsections (a) or (b), convert to the adjusted weekly wage as described in section (9) of this rule.

(5) **The job at aggravation was employment with an annual salary set by contract**:

(a) Divide the documented annual salary by 52 weeks to arrive at the weekly wage; and

(b) Convert the weekly wage to the adjusted weekly wage as described in section (9) of this rule.

(6) **The job at injury was other than the kinds of employment listed in section (3) of this rule; or the job at aggravation was other than the kinds of employment listed in sections (4) or (5) of this rule**: Calculate the weekly wage by using subsection (a) or (b), whichever is applicable. All figures used in determining a weekly wage by this method shall be supported by verifiable documentation such as the worker's state or federal tax returns, payroll records, or reports of earnings or unemployment insurance payments from the Employment Department.

(a) Combine the worker's earned income and any unemployment insurance payments from the 52 weeks prior to the injury, aggravation, or last day worked prior to the aggravation.

Divide the total by 52; or

(b) If the worker was medically unable to work for any period during the 52 weeks prior to the injury, aggravation, or last day worked prior to the aggravation; and the worker presents written verification of medical incapacity from a licensed physician, calculate the weekly wage by dividing the worker's earned income and any unemployment insurance payments for the 52 weeks by the number of weeks the worker was medically able to work; and

(c) After arriving at the weekly wage through subsection (a) or (b), convert the weekly wage to the adjusted weekly wage as described in section (9) of this rule.

(7) **At time of injury, the worker held one or more jobs in addition to the job at injury.** This section does not apply if the job at injury was volunteer employment or other covered employment with no wages. Calculate the weekly wage as described in subsection (a) and, if applicable, subsection (b). The worker's weekly wage shall be the higher of the two calculations.

(a) Calculate the weekly wage using the 52 week averaging method described in section (6) of this rule; and,

(b) If the worker's job at injury was permanent, year-round employment; employment with an annual salary set by contract; or self employment, use the weekly wage on which temporary total disability was based; and,

(c) After arriving at the weekly wage through subsection (a) or (b), convert the weekly wage to the adjusted weekly wage as described in section (9) of this rule.

(8) **The worker held two or more jobs at aggravation**: Calculate the weekly wage as described in subsection (a) and, if applicable, subsection (b). The worker's weekly wage shall be the higher of the two calculations.

(a) Calculate the weekly wage using the 52 week averaging method described in section (6) of this rule; and

(b) If one or more of the worker's jobs at aggravation was permanent, year-round employment or employment with an annual salary set by contract, calculate the weekly wage using the method described in section (4) or (5) of this rule, whichever is applicable. When making this calculation for two or more jobs, use only the job which yields the highest weekly wage; and

(c) After arriving at the weekly wage through subsection (a) or (b), convert the weekly wage to the adjusted weekly wage as described in section (9) of this rule. When making the employer contact required under subsection (9)(a), contact the employer for whom the worker worked the most hours during the applicable 52 week period if the weekly wage was derived from the calculation under subsection (a). If the weekly wage was derived from the calculation under subsection (b), contact the employer for the job which yielded the highest weekly wage.

(9) **Adjusted weekly wage**: After arriving at the weekly wage through section (3), (4), (5), (6), (7) or (8) of this rule, establish the adjusted weekly wage as described in subsection (a), (b), or (c), whichever is applicable. All cost-of-living or collective bargaining adjustments are based on changes from the date of injury or aggravation, or last day worked prior to aggravation,

to the date of calculation.

(a) Contact the employer for the job at injury or aggravation regarding any cost-of-living or collective bargaining adjustments for workers performing the same job. Adjust the worker's weekly wage by any percentage increase or decrease; or

(b) If the employer for the job at injury or the job at aggravation is no longer in business and the worker's job was covered by a union contract, contact the applicable union for any cost-of-living or collective bargaining adjustments. Adjust the worker's weekly wage by the percentage increase or decrease; or

(c) If the employer for the job at injury or the job at aggravation is no longer in business or does not currently employ workers in the same job category, adjust the worker's weekly wage by the appropriate factor from the cost-of-living matrix.

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436-120-0320 Determining Eligibility and Contact of Worker

(1) The insurer shall contact a worker with an accepted disabling claim or claim for aggravation to begin the eligibility determination process within five days of the occurrence of one of the following:

(a) The insurer receives a request for vocational assistance from the worker or the worker's authorized representative. If the insurer does not know the worker's permanent limitations, the insurer shall request this information from the attending physician within 14 days of receiving the request for vocational assistance, unless medical reports document such a determination is premature. If the attending physician determines the request is premature, the insurer may postpone the determination of eligibility until the projected or actual permanent limitations due to the injury are known. If there is such a delay, the insurer shall notify the worker and the worker's representative, if applicable; or

(b) The insurer receives a medical or investigative report with sufficient information to document a need for vocational assistance. For sufficient information to exist, there must be medical information which gives projected or actual permanent limitations due to the injury.

(2) Within five days of determining the claim qualifies for closure because the worker is medically stationary, the insurer shall contact the worker to determine eligibility for vocational assistance. If the claim qualifies for closure under ORS 656.268 (1), the insurer may postpone the determination until the worker is medically stationary or there is sufficient medical information, whichever occurs first. The insurer is not required to determine eligibility if:

(a) Eligibility has previously been determined; or

(b) The worker has returned to regular or other suitable employment with the employer at injury or aggravation. If the director subsequently determines the worker did not return to suitable employment, the insurer must determine eligibility.

(3) Nothing in these rules prevents the insurer, at its own discretion, from finding a worker eligible and providing vocational assistance prior to the conditions specified in section (1) and (2) of this rule.

(4) The worker shall, upon written request, provide the insurer with information needed to determine eligibility. The insurer may set a reasonable time for submission of the necessary information. Such information may include, but is not limited to, work history and education.

(5) The insurer shall determine whether the worker is eligible for vocational assistance within 30 days of the contact required in sections (1) or (2) of this rule. If there are delays as discussed in subsection (1)(a) of this rule, the insurer shall make the determination within 30 days of receiving the necessary information.

(6) The individual making the eligibility determination shall hold certification under OAR 436-120-0830. However, a claims examiner certified under OAR 436-055 may determine if a worker meets eligibility criteria under OAR 436-120-0330(1) through (4).

(7) Upon determining the worker eligible, the insurer and worker shall jointly select a vocational assistance provider pursuant to OAR 436-120-0370. Unless the insurer and worker are unable to agree on a provider or the worker is temporarily unable to participate, the insurer shall, as described in OAR 436-120-0610(3), notify the worker of the selection of a provider no later than 20 days from the date the insurer determined the worker eligible.

Stat. Auth.: ORS 656.726(3)
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Eligibility for Vocational Assistance: Conditions

436-120-0330 A worker is eligible for vocational assistance when the six following conditions have been met:

(1) The worker has sustained an accepted disabling compensable injury. For purposes of determining eligibility, an accepted disabling compensable injury includes an accepted aggravation claim but not openings after the expiration of aggravation rights. However, a worker who retains eligibility or a worker who should have been found eligible under a prior opening of the claim will not lose entitlement to eligibility upon entering Board's Own Motion status; and

(2) Prior to claim closure, medical evidence indicates that, because of the injury, the worker will likely have a permanent disability; or, the worker has a Determination Order, Notice of Closure, Reconsideration Order, Opinion and Order of a Referee, Order on Review by the Workers' Compensation Board, decision of the Court or an approved stipulation which grants a permanent disability award. The following do not, of themselves, preclude a worker's eligibility for vocational assistance:

(a) A finding that a worker is not entitled to an additional award of permanent disability

on aggravation, or

(b) A finding that a worker is not entitled to a permanent disability award because of an offset of permanent disability from a prior claim, or

(c) The disposition of permanent disability through a claim disposition agreement (CDA).

(3) The worker is authorized to work in the United States; and

(4) The worker is available in Oregon for vocational assistance. The insurer shall consider the worker available in Oregon if the worker lives within commuting distance of Oregon or documents, in writing, willingness to relocate to or within commuting distance of Oregon within 30 days of being found eligible. The worker is responsible for costs associated with being available in Oregon.

(5) As a result of the limitations caused by the injury or aggravation, the worker:

(a) Is not able to return to regular employment;

(b) Is not able to return to any other suitable and available work with the employer at injury or aggravation; and

(c) Has a substantial handicap to employment and requires assistance to overcome that handicap.

(6) None of the reasons for ineligibility under OAR 436-120-0350 applies under the current opening of the claim.

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436-120-0340 Determining Substantial Handicap

If a file review does not show the worker has a substantial handicap to employment, the insurer shall perform a substantial handicap evaluation as part of the eligibility determination. The evaluation is subject to the following conditions:

(1) The insurer shall review, analyze, and document the following information:

(a) The worker's relevant work history. For at least the preceding five years this history shall include, but is not limited to, job titles, Dictionary of Occupational Titles codes, dates of employment, and descriptions of job duties;

(b) Level of education, proficiency in spoken and written English or other languages, where relevant, and achievement or aptitude test data if it exists;

(c) Adjusted weekly wage as determined under OAR 436-120-0310 and suitable wage as

defined by OAR 436-120-0005(12)(a);

(d) Permanent limitations due to the injury;

(e) An analysis of the worker's transferable skills, if any;

(f) If applicable, a list of jobs for which the worker has transferable skills, including the Dictionary of Occupational Titles codes;

(g) An analysis of the worker's labor market utilizing Employment Department information such as the Occupational Program Planning System (OPPS) and wages-offered data. The insurer may also use other standard labor market reference materials. In cases where Employment Department and other standard labor market data are not sufficient to make a decision about substantial handicap, the insurer shall perform individual labor market surveys as described in OAR 436-120-0420(7); and

(h) Consideration of the vocational impact of any limitations which existed prior to the injury.

(2) The individual who determines whether the worker is eligible for vocational assistance based on a substantial handicap assessment shall sign the following statement:

My signature certifies I have reviewed and analyzed the material referenced in this evaluation report in making my decision regarding whether this worker is eligible for vocational assistance.

Stat. Auth.: ORS 656.726(3)
Stat. Impltd.: ORS 656.340(5) and (6)
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436-120-0350 Ineligibility and End of Eligibility for Vocational Assistance

Under the current opening of a claim, a worker found ineligible or whose eligibility ends under this rule may again become eligible only through the redetermination process described in OAR 436-120-0360. A worker is ineligible or the worker's eligibility ends when one or more of the following eighteen conditions apply:

(1) The worker does not or no longer meets the eligibility requirements as defined in OAR 436-120-0330. When ending eligibility under this section, the following apply:

(a) The insurer must have obtained new information regarding, but not limited to, one of the following: the worker's limitations due to the injury as established by the attending physician or a preponderance of medical evidence based on objective medical findings, the worker's work history or education, or a change in the weekly wage upon which the temporary total disability rate is calculated.

(b) New information is defined as information which did not exist or which the insurer could not have discovered with reasonable effort at the time the insurer determined eligibility.

(2) The worker's lack of suitable employment is not due to the limitations caused by the injury. Under ORS 656.268(12), however, if the attending physician has approved the worker's return to employment and there is a labor dispute in progress at the place of employment, the refusal of the worker to return to that employment will not cause the loss of any vocational

assistance available under these rules.

(3) The worker has been employed in suitable employment after the injury or claim for aggravation for 60 days. This provision shall not apply if the worker is not medically stationary, and further vocational assistance is required to overcome obstacles to the worker's continued employment.

(4) The worker refused an offer of suitable employment, or left suitable employment after the injury or aggravation for a reason unrelated to the limitations due to the compensable injury. The insurer shall verify that the employment meets all the requirements of suitable employment as defined in OAR 436-120-0005(11). If the employer-at-injury offers employment to a non-medically stationary worker, the offer must be made in accordance with OAR 436-060.

(5) The worker refused or failed to make a reasonable effort in available light-duty work intended to result in suitable employment. Prior to finding the worker ineligible or ending eligibility, the insurer shall document the existence of one or more suitable jobs which would have been available for the worker upon successful completion of the light-duty work. If the employer-at-injury offers such employment to a non-medically stationary worker, the offer must be made in accordance with OAR 436-060.

(6) The worker has declined or has become unavailable for vocational assistance. The insurer shall determine whether the worker is declining or is not available for good cause. Good cause shall include, but is not limited to, medically documented worker illness and the documented serious illness or death of an immediate family member. If the insurer does not consider the reason for declining services or unavailability to be for good cause, the insurer shall warn the worker as described in OAR 436-120-0610(9) prior to finding the worker ineligible or ending the worker's eligibility under this section.

(7) The worker has failed, after written warning, to participate fully in an evaluation of eligibility or a vocational evaluation required by the insurer, or to provide requested information which is material to such evaluations.

(8) The worker has failed, after written warning, to participate fully in the development of a return-to-work plan. However, no written warning is required if, after the counselor and worker have mutually agreed in writing upon a return-to-work goal, the worker refuses a suitable training site.

(9) The worker has failed, after written warning, to comply fully with the worker's responsibilities in a return-to-work plan. Written warning is not required if the worker stops attending training without good cause.

(10) The worker has stopped attending training without notifying either the vocational assistance provider or the insurer.

(11) The worker's lack of suitable employment cannot be resolved by currently providing vocational assistance. This includes circumstances in which the worker cannot benefit from, or participate in, vocational assistance because of medical conditions.

(12) The worker has misrepresented a matter material to evaluating eligibility or providing vocational assistance.

(13) The worker has been determined under ORS 656.268 to have no permanent disability, except as provided in OAR 436-120-0330(2)(a)(b)(c).

(14) The insurer has denied the claim under which the eligibility was determined.

(15) The worker has refused, after written warning, to return property provided by the insurer or reimburse the insurer after the insurer has notified the worker of the repossession; or the worker has misused funds provided for the purchase of property or services under OAR 436-120-0700 and 0710. No vocational assistance shall be provided under the current or subsequent openings of the claim until the worker has returned the property or reimbursed the funds.

(16) The worker, after written warning, has continued to sexually harass or threaten to physically abuse the vocational assistance provider, trainer, or employees of the insurer or department. Written warning is not necessary for the insurer to end the eligibility of a worker who physically abuses any party to the vocational assistance process. This section does not apply if such behavior is the result of a documented medical or mental condition. In such a situation, eligibility should be ended under section (11) of this rule.

(17) The worker has entered into a claim disposition agreement (CDA) which disposes of vocational assistance eligibility. The following conditions apply:

(a) The insurer shall not suspend vocational services and the worker must continue to participate in vocational services until the date the CDA is filed with the Workers' Compensation Board (Board), unless the parties agree in writing to such suspension.

(b) If the Board disapproves or the worker withdraws the CDA, the insurer shall resume vocational assistance.

(c) The insurer shall end eligibility when the Board approves the CDA.

(d) When ending eligibility, the insurer shall file a closing status report as described in OAR 436-120-0600(4). No notice under OAR 436-120-0610 is required.

(18) The worker has received maximum direct employment services under OAR 436-120-0430(3) or (4) and is not entitled to other categories of vocational assistance.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
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436-120-0360 Redetermining Eligibility for Vocational Assistance

Upon notice of one or more of the circumstances listed in sections (1) through (8) of this rule, the insurer shall redetermine the eligibility of a worker previously found ineligible or whose eligibility ended. If the worker's eligibility previously ended, the insurer shall presume the worker still has a substantial handicap to employment unless it possesses new information as defined in OAR 436-120-0350(1)(b). The insurer shall complete the eligibility determination within 35 days if a substantial handicap determination is performed; otherwise, the insurer shall

complete the determination within 14 days.

(1) The worker, for good cause, declined or was not available for services as described in OAR 436-120-0350(6), or the worker's lack of suitable employment could not be resolved by the provision of vocational services as described in OAR 436-120-0350(11), and those circumstances have changed so there would no longer be a barrier to vocational assistance. Prior to beginning redetermination, the insurer may require the worker to provide documentation the barrier no longer exists, including medical or psychological reports relating to noncompensable conditions;

(2) The insurer found the worker ineligible or ended the worker's eligibility because the worker was not available in Oregon as described in OAR 436-120-0330(4), and the worker becomes available. If the insurer's notice of ineligibility or end of eligibility was issued on or after January 1, 1995, the worker must request redetermination within six months of the worker's receipt of the insurer's notice.

(3) The worker's eligibility ended or the worker was found ineligible because the insurer denied a claim, and the claim is later accepted and all appeals exhausted;

(4) The insurer determined it erred in a previous eligibility determination or in the original decision to end eligibility;

(5) The insurer previously found the worker ineligible or ended the worker's eligibility because the worker was determined under ORS 656.268 to have no permanent disability and the worker later is awarded permanent disability;

(6) The insurer previously found the worker ineligible or ended the worker's eligibility because the worker was not authorized to work in the United States, and the worker is now authorized. If the insurer's notice of ineligibility or end of eligibility was issued on or after January 1, 1995, the worker must request redetermination within six months of the date the authorization to work is granted;

(7) Prior to claim closure a worker's limitations due to the injury became more restrictive, as documented by the attending physician or a preponderance of medical evidence. Such changes in limitations must be based on objective medical evidence supported by objective findings; or

(8) Prior to the worker becoming medically stationary, the insurer ended the worker's eligibility or found the worker ineligible because the worker had returned to work or accepted an offer of employment. Later the physician rescinded the release based on medical evidence supported by objective findings; or the worker or the worker's representative requested a redetermination within 60 days of the mailing date of the Notice of Closure or Determination Order.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.340
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436-120-0370 Selection of Vocational Assistance Provider

(1) The insurer shall select an individual certified under OAR 436-120-0830 to determine

if the worker is eligible for vocational assistance. The insurer may use its own certified staff, or assign the worker to a vocational assistance provider holding authorization under OAR 436-120-0800.

(2) For a worker determined eligible for vocational assistance, the insurer shall contact the worker or the worker's representative, if applicable, and the parties shall jointly select a vocational assistance provider.

(3) When the worker and insurer are unable to agree on a vocational assistance provider, the insurer shall notify the Workers' Compensation Division immediately. The division will resolve the dispute in accordance with the provisions of OAR 436-120-0008(1). If agreement is not reached, the director shall select an authorized provider. Such selections are at the sole discretion of the director. In making such selections the director may consider various criteria including the ability of the provider to meet any special needs of the worker and the geographic proximity of the provider to the worker.

(4) The insurer and the worker may jointly select a new vocational assistance provider. If the parties disagree that a new provider is needed, the division will resolve the dispute as provided in OAR 436-120-0008(1). If the division determines a new provider is needed and must make the selection, it will do so as described in section (3) of this rule.

(5) Upon notification of suspension or revocation of a vocational assistance provider's authorization under OAR 436-120-0850, the insurer shall contact affected workers within seven days for reassignment to another mutually acceptable provider authorized under OAR 436-120-0800.

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436-120-0400 Selection of Category of Vocational Assistance

Within 30 days of the date of the insurer's referral to a vocational assistance provider, but no later than 50 days after the determination of eligibility, the insurer shall select the category of vocational assistance to which the worker is entitled and shall notify the worker of the reason for its decision in accordance with OAR 436-120-0610. The insurer shall document by report or file notes the rationale for its decision. The following are the categories of vocational assistance and the criteria to be used in selection:

(1) **A vocational evaluation**, which assists the insurer in determining the category of services necessary for a worker to obtain suitable new employment. Vocational evaluations are subject to the conditions described in OAR 436-120-0410 and 0420. The insurer shall perform a vocational evaluation only if the insurer does not have sufficient information to choose between training and direct employment services or to determine if the worker can benefit from vocational assistance.

(2) **A direct employment plan**, which assists a worker to obtain suitable new employment under the conditions described in OAR 436-120-0430. The insurer shall develop a direct employment plan for an eligible worker when the insurer finds one or more direct employment services under OAR 436-120-0430 sufficient to enable the worker to obtain suitable new employment. A finding that a direct employment plan is sufficient also requires a finding that the worker has the necessary transferable skills for the new employment. Direct employment services are appropriate only if training will not bring the worker a wage significantly closer to 100 percent of the wage calculated under OAR 436-120-0310.

(3) **A training plan**, which assists a worker to obtain suitable new employment under the conditions described in OAR 436-120-0440 and 0450. The insurer shall develop a training plan for an eligible worker when the insurer finds a direct employment plan is not sufficient for the worker to obtain suitable new employment, other than by reason of the current, short-term conditions in the worker's labor market; and, the worker, only with training, can return to employment which pays a wage significantly closer to 100 percent of the wage calculated under OAR 436-120-0310. "Significantly closer" may vary depending on several factors, including, but not limited to, the worker's wage at injury, adaptability, skills, geographic location, limitations and the potential for the worker's income to increase with time as the result of training.

(4) The insurer shall reconsider the category of vocational assistance if the worker has a change in permanent limitations due to the injury which affects the suitability of the vocational assistance selected. The insurer shall make its decision within 30 days of receiving a report documenting such a change in limitations as established by a preponderance of medical evidence based on objective findings.

(5) The insurer may reconsider the category of vocational assistance under other conditions which include, but are not limited to, the following:

(a) A change in the worker's circumstances which could not have been predicted at the time the selection was made, or

(b) A change in the labor market, or

(c) The category of vocational assistance proves to be inappropriate.

(6) If, pursuant to sections (4) and (5) of this rule, the insurer selects a different category of vocational assistance, the insurer shall notify the worker of the reason for the change in accordance with OAR 436-120-0610.

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436-120-0410 Vocational Evaluation

(1) An individual certified in accordance with OAR 436-120-0830 shall complete a vocational evaluation and provide the insurer with a report within 45 days of the insurer's selection of vocational evaluation under OAR 436-120-0400 unless the necessary information cannot be obtained, with reasonable effort, within that time.

(2) Vocational evaluations shall incorporate, but not duplicate, information obtained from an eligibility evaluation or any prior vocational evaluation.

(3) The vocational evaluation report shall include, but is not limited to, the following, unless the information is available as part of an eligibility evaluation or is not relevant:

(a) A description of the worker's current medical condition and limitations due to the injury;

(b) A description of the worker's education and training;

(c) A description of the worker's employment history including job durations, wages, specific job duties, and Dictionary of Occupational Titles codes;

(d) A description of the worker's transferable skills;

(e) A summary of any vocational testing, on-the-job evaluations, work evaluations and other assessments related to potential vocational objectives;

(f) A listing of the geographical areas where the worker is willing to work in addition to that described in OAR 436-120-0005(11)(b);

(g) Any relevant pre-existing conditions;

(h) Other information including, but not limited to, job analyses and labor market surveys related to potential vocational objectives. The labor market survey should include a discussion of the worker's work experience, training and limitations in relation to the job requirements described by employers contacted;

(i) A conclusion which describes the category and extent of vocational assistance, either direct employment services or training, needed for the worker to obtain suitable employment; and

(j) The worker's signature indicating the worker has read and received a copy of the report. Certain information may be excluded from the report, as allowed by ORS 192.525. The signature does not imply the worker's agreement with the conclusions of the evaluation. The provider shall allow the worker to attach written comments to the evaluation report.

(4) Upon receipt of the vocational evaluation report, the insurer shall decide within ten days whether the worker shall receive direct employment services or training, or is unable to benefit from vocational assistance, and shall notify the worker in accordance with OAR 436-120-0610.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
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436-120-0420 Vocational Evaluation: Components

A vocational evaluation includes any one or more of the following components:

(1) **Vocational testing**, which is used to measure intelligence, aptitudes, achievements, abilities, interests and personality, by using standard and generally accepted measures and is

subject to the following conditions:

(a) The person administering and interpreting the test shall have the certification and qualifications to do so;

(b) The test administrator shall submit a written report to the insurer which shall include a description of the test results and their relationship to vocational goal planning.

(2) **Work evaluation**, which is the use of standardized work samples, psychometric and other vocational tests in a systematic and comprehensive process to determine a worker's vocational abilities and needs, and the interpretive report which documents the results and meaning of the evaluation. The person performing this evaluation shall be certified as a Certified Vocational Evaluation Specialist (CVE) or Certified Work Adjustment Specialist (CWA) by the Commission on Certification of Work Adjustment and Vocational Evaluation Specialists or have been certified to perform work evaluations by the division on or before December 31, 1994.

(3) **On-the-job evaluation**, which is provided to evaluate a worker's work traits, aptitudes, limitations, potentials and habits in an actual job environment, with specific focus on a particular occupation or industry. An on-the-job evaluation is subject to all of the following conditions:

(a) The evaluation shall focus on a specific job, occupation or industry and shall include a written description of the vocational and related areas to be assessed;

(b) The counselor shall perform a job analysis of the job to be evaluated and will proceed with the evaluation only if the job is within the worker's capacities. The insurer shall submit the job analysis to the attending physician if there is any question about the appropriateness of the job;

(c) The evaluation shall normally be no less than five hours daily for four consecutive days and shall normally last no longer than 30 days. For pre-1986 injuries, the division will not reimburse for more than two on-the-job evaluations or evaluations which do not meet the guidelines in this subsection without prior administrative approval;

(d) The evaluation is primarily for the worker's benefit, rather than the participating employer's; does not imply any employer/employee relationship and will not necessarily result in a permanent job with the cooperating employer; and the cooperating employer does not expect a substantial gain from the worker's activity. The value of any product produced or work performed shall be offset by the evaluator's time in providing the evaluation;

(e) The worker being evaluated does not displace an employee; and

(f) The evaluation shall result in a written report which details the worker's performance in the areas originally identified for assessment.

(4) **Situational assessment**, which is a systematic procedure to evaluate a worker's aptitude or work behavior in a particular learning or work setting. Its focus may be to determine a worker's overall vocational functioning or to answer specific questions about certain types of work behaviors. A situational assessment is subject to the following conditions:

(a) The situational assessment requires these steps: planning and scheduling observations; observing, describing and recording work behaviors; organizing, analyzing and interpreting data;

and synthesizing data including behavioral data from other pertinent sources.

(b) The assessment shall normally be no less than five hours daily for four consecutive days and shall normally last no longer than 30 days. For pre-1986 injuries, the division will not reimburse for more than two assessments or assessments which do not meet the guidelines in this subsection without prior administrative approval.

(5) **Work adjustment**, which uses work-related activities to assist workers in understanding the meaning, value, and demands of work. It may include the assistance of a job coach. For pre-1986 injuries the division will not reimburse for work adjustment longer than eight weeks without prior administrative approval.

(6) **Job analysis**, which is the detailed description, or making the description, of the physical and other demands of a job or occupational goal based on direct observation of the job.

(7) **Labor market survey**, which is the information compiled, or the compiling activity, to determine the wages, hiring practices and availability of suitable employment with regard to a specific worker, obtained from direct contact with employers, others having actual labor market information or from other surveys of this kind completed within 90 days of the report date.

(a) A labor market survey is not needed when the question is availability of employment and the Oregon Employment Department's Occupational Program Planning System (OPPS) or other statistical labor market resources designated by the director support a reasonable labor market; or if there is a question about wages and adequate information is available from the Employment Department's wages-offered data. When using the Employment Department's wages-offered data, the insurer shall use the median wage (Q2) unless the insurer documents factors which would qualify the worker for a different wage.

(b) A labor market survey is needed when the sources given in subsection (a) or other standard labor market reference materials do not have adequate information upon which to base a decision, or there are questions about a worker's specific limitations, training and skills which must be addressed with employers to determine if a reasonable labor market exists.

(c) For a labor market survey to be valid, the questions asked shall relate to specific job goals; the person giving the information must be the one who hires for the position being discussed or has direct knowledge of the job's requirements; and the job being researched must exist at the firm contacted.

(d) The labor market survey report shall include, but is not limited to: the date of contact; firm name, address and telephone number; name and title of person contacted; the qualifications of persons recently hired; physical requirements; wages paid; condition of hire (full-time, part-time, seasonal, temporary); date and number of last hire(s); and available and anticipated openings.

(e) Specific openings found in the course of a labor market survey are not, in themselves, proof a reasonable labor market exists.

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Amended and Renumbered from OAR 436-120-075 and 081, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95

436-120-0430 Direct Employment

(1) Direct employment services consist of direct employment plan development, which may include any of the vocational evaluation components listed under OAR 436-120-0420, and plan implementation. A direct employment plan assists a worker to obtain suitable new employment, with the help of one or more direct employment services as follows:

(a) Employment counseling.

(b) Job search skills instruction, which is used to teach workers how to write resumes, research the job market, locate suitable new employment, complete employment applications, interview for employment, and develop other skills related to looking for suitable new employment.

(c) Job development, which is identifying, targeting and contacting, or assisting the worker to contact appropriate prospective employers, and assisting the worker in related return-to-work activity. In requiring worker participation in job development activities, the insurer shall consider the worker's job search skills.

(d) Job analysis as provided in OAR 436-120-0420(6).

(e) Return-to-work follow-up, which is contacting a worker and employer after the worker returns to work to insure the work is suitable and providing necessary assistance, while the worker remains eligible, to help continue the employment.

(f) Other services of a direct employment nature. For pre-1986 injuries, administrative approval is required.

(2) The insurer shall provide return-to-work follow-up during the first 60 days after the worker becomes employed, and for as long thereafter as the insurer finds necessary to help continue the employment while the worker remains eligible under section (3) or (4) of this rule.

(3) The insurer shall provide an eligible worker with four months of direct employment services dating from the date the insurer approves a direct employment plan or the completion date of an authorized training plan. This rule does not apply to labor market surveys or job analyses as part of a vocational evaluation, or to return-to-work follow-up during the first 60 days after the worker becomes employed. Direct employment services may be available beyond the expiration date if circumstances beyond the worker's control caused the worker to receive less than the normal extent of services and to need further services. For pre-1986 injuries, such additional services require administrative approval.

(4) If the worker is not medically stationary upon the completion of the four month period and has not received sufficient direct employment services, the insurer shall continue direct employment services until claim closure. For the purpose of this section, "sufficient" means the worker's permanent limitations are defined; the worker has adequate job search skills; and suitable employment exists in a reasonable quantity, regardless of whether positions are currently available.

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436-120-0440 Training

(1) A training plan assists a worker to obtain suitable employment and consists of one or more of the kinds of training described in this section, progress monitoring and, as necessary, one or more of the direct employment services under OAR 436-120-0430. Training services consist of training plan development, which may include any of the vocational evaluation components listed under OAR 436-120-0420, and plan implementation.

(2) Training of any and all kinds is limited to an aggregate duration of 16 months, subject to extension to 21 months by the director for a worker with an exceptional disability resulting from the compensable condition(s) and any limitations which existed prior to the injury. "Exceptional disability" is defined as disability equal to or greater than the complete loss, or loss of use, of both legs. Exceptional disability also includes brain injury which results in impairment equal to or greater than Class III as defined in OAR 436-035.

(3) A worker enrolled and actively engaged in training shall receive temporary disability compensation subject to OAR 436-120-0740 and OAR 436-060. At the insurer's discretion, training costs may be paid for periods longer than 21 months, but in no event shall temporary total disability compensation be paid for a period longer than 21 months. Temporary disability compensation and vocational assistance costs during training are also subject to the conditions under OAR 436-120-0710, 0720, 0730, and 0750.

(4) The selection of plan objectives and kind of training shall attempt to minimize the length and cost of training necessary to prepare the worker for suitable employment. Notwithstanding OAR 436-120-0330(4), the director may order the insurer, or the insurer may elect, to provide training outside Oregon if such training would be more timely, appropriate or cost effective than other alternatives. The individual who develops and monitors such out-of-state training must be certified under OAR 436-120-0810.

(5) The insurer shall not provide any further training to a worker who has completed one training plan unless the worker has sustained a compensable aggravation which renders the worker incapable of obtaining suitable employment, or the previous plan was inadequate to prepare the worker for suitable employment because of an error or omission by the insurer. For pre-1986 injuries such additional training plans require prior administrative approval. Temporary fluctuations in the labor market shall not be a rationale for further training.

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436-120-0450 Training: Kinds and Standards

The kinds of training are as follows:

(1) **On-the-job training**, which is a wage-paying job furnishing instruction in the job skills necessary to qualify the worker for continuation of permanent, suitable employment with the training employer. On-the-job training shall be the first option considered in developing a training plan. The following conditions apply:

(a) Training time is limited to a duration of 12 months;

(b) Wages are subsidized as specified by a contract among the training employer, the insurer, and the worker. The on-the-job training contract shall include, but is not limited to, the worker's name and social security number; the employer's legal business name, Workers' Compensation Division Employer Registration number, and the name of the individual providing the training; the training plan start and end dates; the title of the job, a description of the job duties, and the skills to be taught; the base wage and the terms of wage reimbursement; and a statement the employer will pay all taxes normally paid on the entire wage and will maintain workers' compensation insurance for the trainee;

(c) The insurer shall not reimburse the training employer 100 percent of the wages for the entire contract period, although the insurer may reimburse 100 percent for periods of time during the contract;

(d) The training employer shall maintain workers' compensation insurance coverage and meet all other applicable state and federal regulations for the duration of the on-the-job training contract; and

(e) The insurer shall pay temporary disability compensation to the worker in accordance with OAR 436-120-0740(2) and shall reduce payment as provided in ORS 656.212;

(f) The training shall prepare the worker for employment in the labor market at large. Training which prepares a worker for a job unique to the training site shall be in conformance with this subsection if the worker and the worker's representative, if applicable, acknowledge in writing that the training may not prepare the worker for jobs elsewhere; and

(g) The worker's time commitment shall be determined by the work schedule normally required by the training employer of regular, full-time employees. The worker's work schedule may be less than full time due to a worker's documented medical condition or class schedule.

(2) **Skills training**, which teaches the worker job skills in a self-contained program under the auspices of a community college, but with the training site at the location of a training employer who teaches the skills on behalf of the college in accordance with a prearranged, written curriculum. Skills training is subject to the following conditions:

(a) Training time is limited to a duration of 12 months;

(b) The training employer makes no guarantee of employing the worker when the training is completed;

(c) The worker does not displace an employee;

(d) The worker does not receive wages;

(e) There is no employer/employee relationship between the worker and training employer; the activity is primarily for the worker's benefit; and the training employer does not expect a substantial gain from the worker. The value of any products produced or work performed is expected to be substantially offset by the value of the supervisory time involved in training the worker;

(f) The training employer has a sufficient number of employees to accomplish its regular work and the training of the worker;

(g) The training employer maintains workers' compensation coverage for subject workers if the training employer is a subject employer;

(h) The training employer, worker and counselor shall review the curriculum at least every three months to assure the worker is making adequate progress; and

(i) The worker's time commitment shall be determined by the work schedule normally required by the training employer of regular, full-time employees. The worker's work schedule may be less than full time due to a worker's documented medical condition or class schedule.

(3) **Sheltered workshop training**, which is provided in a facility established and operated to provide evaluation, training and employment for severely disabled individuals.

(4) **Basic education**, which raises the worker's relatively low level of education so the worker can obtain suitable employment directly or through participation in other training, is limited to a duration of six months. It is normally provided in conjunction with on-the-job training, skills training or formal training. The insurer may provide basic education without other training components if the provision of basic education will lead to suitable employment in an identified vocational goal.

(5) **Formal training**, which teaches the worker job skills in a vocational school, community college or other post-secondary educational facility. The following conditions apply:

(a) The worker shall take the maximum courseload consistent with the worker's abilities, limitations and length of time since the worker last attended school;

(b) Courses shall relate to the vocational goal; and

(c) The training facility shall be a community college or college or university which is part of a state system of higher education, or a facility licensed by an appropriate licensing body.

(6) **Other services of a training nature.** For pre-1986 injuries, administrative approval is required.

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436-120-0460 End of Training and Services After Training

(1) Training shall end if any of the following applies:

(a) The worker is not capable of performing the vocational objective because of permanent limitations due to the injury, as documented by the attending physician or a preponderance of medical evidence based on objective medical findings.

(b) The worker's performance in the training falls below the level which is satisfactory to obtain employment in the field which is the vocational objective. In an academic program, failure for two grading periods to maintain at least a 2.00 grade point average each grading period, or failure for two grading periods to complete the minimum credit hours required under the training plan, is prima facie evidence of unsatisfactory performance. The insurer shall give the worker written warning of the possible end of training at the end of the first grading period of unsatisfactory performance.

(c) The worker has failed, after written warning, to meet the requirements of the training plan.

(d) The worker has successfully completed training.

(e) The worker is not enrolled and actively engaged in the training. However, none of the following will be considered as ending the worker's training status:

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

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

(C) A period of illness or recuperation which does not prevent completion of the training by the planned date.

(f) The worker has obtained, or receives a written bona fide offer of, suitable employment. The insurer shall use the method described in OAR 436-120-0500(4) to determine if the employment is suitable.

(g) Eligibility ends under OAR 436-120-0350.

(2) The worker is entitled to job placement assistance after completion of training, using services described in OAR 436-120-0430.

(3) When an eligible worker returns to work following training, the insurer shall monitor the worker's progress in accordance with OAR 436-120-0430(2) to assure the suitability of employment before ending eligibility under OAR 436-120-0350(3).

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436-120-0500 Return-to-Work Plans: Development and Implementation

(1) The provider shall develop a return-to-work plan and submit it to the insurer with a copy to the worker and worker's representative, if applicable, no later than:

(a) Thirty days after the selection of direct employment assistance under OAR 436-120-

0400 or 0410(4); or,

(b) Two months after the selection of training assistance under OAR 436-120-0400 or 0410(4). Circumstances beyond the insurer's and worker's control may necessitate an extension of this time frame. Such circumstances include, but are not limited to:

(A) The serious documented illness or personal or family emergency of the worker or vocational counselor. However, if the counselor is unable to provide assistance for an extended period of time, the insurer is responsible for ensuring the case is assigned to another counselor with the same provider, or another provider in accordance with OAR 436-120-0370.

(B) The insurer is unable, despite reasonable effort, to secure medical or psychological information, necessary testing or required evaluation(s) in a timely manner.

(C) The parties, despite reasonable effort, are unable to select a vocational goal.

(2) Within 14 days of receipt of a proposed return-to-work plan signed by the worker and plan developer, the insurer shall approve or reject the plan and notify the parties as described in OAR 436-120-0610(6). If the insurer is unable to make a decision within this time frame because of insufficient data, the insurer shall notify the parties as described in OAR 436-120-0610(4).

(3) The insurer shall file the approved return-to-work plan with the division as described in OAR 436-120-0600.

(4) If, during development or implementation of a return-to-work plan, an employer offers the worker a job, the insurer shall determine the job's suitability by performing a job analysis, verifying the suitability of the wage as defined in OAR 436-120-0005(12)(b), and confirming the offer is for a bona fide, suitable job as defined in OAR 436-120-0005(11). The job analysis must be approved by the attending physician or qualified facility designated by the attending physician. If the job proves suitable, the insurer shall then only provide assistance to help the worker return to work with the employer. The insurer shall provide return-to-work follow-up during the first 60 days after the worker becomes employed. If return to work with the employer proves to be unfeasible or, during the 60 day follow-up the job proves unsuitable, the insurer shall immediately resume the interrupted services.

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436-120-0510 Return-to-Work Plan Support

(1) Return-to-work plans shall be in the form prescribed by the director.

(2) If material pertinent to a return-to-work plan is contained in a previous eligibility or vocational evaluation, the insurer may attach a copy of the evaluation to the plan.

(3) Return-to-work plan support shall contain, but is not limited to, the following:

(a) Specific vocational goal(s) and projected return-to-work wage(s). The plan support shall provide justification in support of the wage, based on labor market information as described in OAR 436-120-0420(7).

(b) A description of the worker's current medical condition, relating the worker's permanent limitations to the vocational goals;

(c) A description of the worker's education and work history, including job durations, wages, Dictionary of Occupational Titles codes and specific job duties;

(d) If a direct employment plan, a description of the worker's transferable skills which relate to the vocational goals and a discussion of why training will not bring the worker a wage significantly closer to 100 percent of the wage calculated under OAR 436-120-0310. If a training plan, a discussion of why direct employment services will not return the worker to suitable employment;

(e) A summary of the results of any evaluations or testing. If the results do not support the goals, the vocational assistance provider shall explain why the goals are appropriate; and

(f) A summary of current labor market information as described in OAR 436-120-0420(7) which shows the labor market supports the vocational goals and documents that the worker has been informed of the condition of the labor market; or

(g) If the labor market information does not support the goals, the vocational assistance provider shall explain why the goals are appropriate. The worker and worker's representative, if any, shall acknowledge in writing an awareness of the poor labor market conditions and a willingness to proceed with the plan in spite of these conditions. In the case of a training plan, this acknowledgment shall include an understanding the insurer will provide no additional training should the worker be unable to find suitable employment because of the labor market.

(4) In addition to the requirements given in section (3) of this rule, training plan support shall contain the following:

(a) A job analysis prepared by the vocational assistance provider in accordance with OAR 436-120-0420(6), signed by the worker and by the attending physician or a qualified facility designated by the attending physician, and based on a visit to a worksite comparable to what the worker could expect after completing training. If the attending physician is unable or unwilling to address the job analysis and does not designate a facility as described above, the insurer may submit the job analysis to a qualified facility of its choice. The insurer shall submit the resulting information to the attending physician for concurrence; and

(b) A signed on-the-job training contract as described in OAR 436-120-0450(1)(b), if applicable; and

(c) A description of the curriculum, which must be term by term if the curriculum is for formal training.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
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436-120-0520 Return-to-Work Plan: Responsibilities of the Eligible Worker and the Provider

(1) An eligible worker shall fully participate and maintain contact with the vocational assistance provider throughout plan development and as required in the plan, and shall inform the vocational assistance provider of anything which might affect the worker's participation in or completion of the plan. In addition, workers in training plans have the following responsibilities:

(a) By the fifth day of each month, the worker shall provide the vocational assistance provider a written report describing the previous month's attendance, training progress, and problems or needs.

(b) The worker shall forward each grade or progress report to the vocational assistance provider within 10 days of the worker's receipt of the report.

(c) In formal training, the worker shall maintain at least a 2.00 grade point average each grading period and shall complete the minimum credit hours required under the training plan.

(d) The worker shall make changes in the curriculum only with insurer approval.

(e) The worker shall advise the provider as soon as possible if anything threatens to interfere with successful completion of training, or by the close of the next working day if the worker stops attending training for any reason.

(2) Vocational assistance providers are responsible for the following:

(a) During plan development, the vocational assistance provider shall actively assist the worker in vocational goal selection by providing resource materials about jobs, training programs (if appropriate), labor markets and other pertinent information; directing information gathering; and otherwise helping the worker analyze and evaluate options.

(b) The vocational assistance provider shall, if needed, visit each training site to plan the curriculum and help the worker enroll. The provider shall contact the worker, trainers and training facility counselors to the extent necessary to assure the worker's participation and progress. For pre-1986 injuries, if the vocational assistance provider fails to verify the worker's participation and progress and additional costs result, the insurer or provider may be required to bear the additional costs, including those costs under OAR 436-120-0750(4).

(c) Prior to submitting the plan to the insurer, the vocational assistance provider shall review the plan and plan support with the worker. Certain information may be excluded, as allowed by ORS 192.525. The provider shall confirm the worker's understanding of and agreement with the plan by obtaining the worker's signature or initials and the date on each page of the plan support.

(d) The provider shall give the worker and the worker's representative copies of the return-to-work plan form and plan support when the worker signs the plan. The form must include the provider's and the worker's responsibilities as described in this rule.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
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436-120-0530 Return-to-Work Plan Review

As the director considers necessary, the Workers' Compensation Division will review return-to-work plans and supporting information for conformance to these rules. If the director chooses not to review a return-to-work plan, this lack of review does not imply the director finds the plan in conformance. If the division finds a return-to-work plan or its supporting information does not conform to these rules:

(1) The division will notify the insurer and vocational assistance provider in writing of the preliminary finding of nonconformance. The notification will inform the insurer of changes or information required to bring the plan into conformance.

(2) The insurer shall, within 30 days of notification of nonconformance, make appropriate changes, supply additional information requested by the division, or explain why no change(s) should be made.

(3) If the insurer does not respond as described in section (2) of this rule or is unable to bring the plan into conformance, the division will return the plan to all parties with notification that the plan does not conform to OAR 436-120.

(4) The director may order the insurer to develop a plan which conforms to these rules if the insurer chooses not to develop an appropriate plan after being notified of nonconformance.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.340
Hist: Filed 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
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Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96.

436-120-0600 Filing of Return-to-Work Plan and Supporting Information and Closing Status Report

(1) The insurer shall file a return-to-work plan with the division within 14 days after insurer approval.

(2) If the vocational goal or category (training or direct employment) of assistance is later changed, the insurer shall file a new plan with the division within 14 days after the insurer approves the new plan. Related goals developed in the course of a direct employment plan do not require filing a new plan. The insurer shall notify the division of changes in the kind of training, training plan dates, or other significant changes by filing an amended plan within 14 days after the insurer approves changes. The insurer, provider, and worker shall initial all changes on the amended plan.

(3) An insurer is not required to include supporting information with its filings of return-to-work plans, unless the director notifies the insurer otherwise.

(4) The insurer shall file a signed closing status report with the division for each worker determined eligible under OAR 436-120-0320 and 0330 within 14 days after eligibility ends. The insurer shall report the following information:

(a) The reason for end of eligibility, date eligibility ended, return-to-work and provider

information, and any other information prescribed by the director.

(b) For post-1985 injuries, the insurer shall also report cost information for eligibility determination and vocational services provided under these rules as required by the director.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.340
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Amended and Renumbered from OAR 436-120-170, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95

436-120-0610 Notices to Worker, Worker's Representative and Department

Every notice to the worker shall be in writing, shall be signed and dated, and shall state the effective date of the action. Every notice shall also give the basis for the decision, the relevant rule(s), the telephone number of the Workers' Compensation Ombudsman, and the worker's appeal rights as given in section (10) of this rule. The insurer shall simultaneously send a copy of the same written, signed notice to the department, and the worker's representative. Failure to simultaneously send a copy of the notice to the worker's representative may result in penalties under OAR 436-120-0900(3) and OAR 436-060-0015(2). The insurer shall notify a worker by means of the return-to-work plan or other written notice whenever the insurer takes any of the actions listed in sections (1) through (9) of this rule:

(1) **Determines the worker is eligible for vocational assistance**. Notices of eligibility shall include the following:

(a) An explanation of the category of service to which the worker is entitled as described in OAR 436-120-0400, if known;

(b) The worker's rights and responsibilities;

(c) Procedures for resolving dissatisfaction with an action of the insurer regarding vocational assistance;

(d) An explanation of the worker's participation in the selection of a provider. This notice shall include the following language in bold type:

"If you have questions about the vocational counselor selection process, contact (use appropriate reference to the insurer). If you still have questions contact the Workers' Compensation Division's toll free number (use appropriate telephone number)."

(e) The current list of vocational assistance providers authorized under OAR 436-120-0800; and

(f) A statement about potential reemployment assistance under OAR 436-110.

(2) **Determines the worker is ineligible for vocational assistance.** The notice shall be sent by both regular and certified mail to the worker and, if applicable, by regular mail to the worker's representative. Notices of ineligibility are subject to the following conditions:

(a) The notice shall include a clear statement that the worker has been found ineligible for vocational assistance under these rules.

(b) If a medically stationary worker is ineligible because of return to regular or other suitable employment with the employer at injury, a notice of ineligibility is required only if the worker or worker's representative requested a determination of eligibility.

(c) Every notice of ineligibility, except those issued because the worker is unable to participate due to medical reasons, shall tell the worker of help which may be available at no cost from the Employment Department or the Vocational Rehabilitation Division. The notice shall also contain a statement about potential reemployment assistance under OAR 436-110. The information detailed in this subsection shall be set off in a separate paragraph and shall contain the telephone number and address of the Preferred Worker Program office.

(d) Notices of ineligibility based on a finding of "no substantial handicap" shall also contain a list of some occupations suitable for the worker.

(3) **Confirms the selection or change of a vocational assistance provider.**

(4) **Responds to a written request for determination of eligibility, approval of a return-to-work plan, or a particular vocational service**. The insurer shall respond to an oral request if made by an unrepresented worker. If the insurer is unable to determine eligibility or make a decision regarding a particular vocational service because of insufficient data, the insurer shall explain what information is necessary and when it expects to determine eligibility or make a decision.

(5) **Makes a decision about or changes the category of assistance to be provided.** If the category of assistance to be provided is direct employment services, the notice shall state the worker is not entitled to training.

(6) **Approves or rejects a return-to-work plan**. The insurer shall send a signed copy of the return-to-work plan form to the worker. Approval of a return-to-work plan implies approval of all the components of the plan as detailed in the plan support. If there are plan components which the insurer does not approve, the insurer shall include this information in the notification of plan approval.

(7) **Ends training, whether or not the insurer anticipates resumption of training**. The notice shall state whether the worker is entitled to further training. The effective date of the end of training letter shall be the worker's last date of attendance.

(8) **Ends eligibility for vocational assistance**. The notice shall be sent by both regular and certified mail to the worker and, if applicable, by regular mail to the worker's representative.

(9) **Warns a worker as required under OAR 436-120-0350 and 0460(1)(b).** All warning notices shall state the reason, the relevant rule(s) and what the worker must do within a specified time to avoid ineligibility, the ending of eligibility, or the ending of training. The warning shall be sent by both regular and certified mail to the worker and, if applicable, by regular mail to the worker's representative.

(10) All notices except those notifying a worker of eligibility or entitlement to training shall contain the worker's appeal rights in bold type, as follows:

"If you disagree with this decision, you should contact (person's name and insurer) within five days of receiving this letter to discuss your concerns.

If you are still dissatisfied, you must contact the Workers' Compensation Division within 60 days of receiving this letter or you will lose your right to appeal this decision. A consultant with the division can talk with you about the disagreement and, if necessary, will review your appeal. The address and telephone number of the division are:

(address and telephone number of the Workers' Compensation Division)"

(11) The director may prescribe other specific contents for the notices required under this rule and that the insurer furnish workers specified written material at specified times.

Stat. Auth.: ORS 656.331(2), ORS 656.726(3)
Stat. Impltd.: ORS 656.283(2), ORS 656.331(1)(b), ORS 656.340
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Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96

436-120-0620 Provision of Information and Release of Records

(1) The insurer, employer at injury, and vocational assistance provider shall provide the information the department requests under these rules about specific claims and about the insurer's vocational assistance program, including vocational assistance cost information, as prescribed by the director. The department may obtain information directly from the employer at injury or provider. The insurer, employer at injury or provider shall supply requested information:

(a) Within 14 days of the department's request if the information is within the insurer's, employer's or vocational assistance provider's possession; or

(b) Within the time specified by the department if the information must be collected or developed.

(2) Upon written request by a worker, a worker's authorized representative or a worker's attending physician, that individual may review the vocational file of the insurer or the department or be provided copies of vocational file information. The attending physician and the "authorized representative," if other than the worker's attorney, must have a written release signed by the worker. The insurer may review the department's file.

(3) All disclosures of vocational information by the department shall be made in accordance with the provisions of the Oregon Public Records Law, ORS 192.410 through 192.505; ORS 657.665 (Employment Department records); ORS 344.600 (Vocational Rehabilitation Division records); and, Title 42 United States Code, sections 290dd-3 and 290ee-3 (drug and alcohol abuse records).

(4) The department may charge a fee for each document, staff time, accounting fees and mailing costs, as prescribed by rules of the director.

(5) The insurer and each vocational assistance provider shall maintain case files, records, reports, receipts and check copies documenting vocational assistance efforts and costs. The

insurer shall maintain these records in accordance with OAR 436-050. The provider shall maintain the records for four years after the end of vocational assistance with that provider, or in a pre-1986 case, for five years after the end of vocational assistance with that provider

Stat. Auth.: ORS 192.410 through 192.505, ORS 656.726(3)
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436-120-0700 Direct Worker Purchases

(1) The insurer shall provide direct worker purchases under the conditions and limitations of this rule and OAR 436-120-0710 as necessary for an eligible worker's participation in vocational assistance; as necessary elements of evaluation, direct employment or training services; and, as necessary to meet the requirements of a suitable job. A worker is no longer eligible for these purchases once eligibility ends unless the purchases are necessary to complete a plan. Direct worker purchases include partial purchase, lease, rental and payment. For pre-1986 injuries, OAR 436-120-0730(5)(a) prescribes further conditions for some purchases over $1,000.

(2) In determining the necessity of direct worker purchases described in OAR 436-120-0710(13) through (18), the insurer shall consider, among all factors, the worker's pre-injury net income as compared with the worker's post-injury net income. Permanent partial disability award payments shall not be considered as income. For the insurer to find the purchase necessary, the worker's pre-injury net income must be greater than the worker's post-injury net income, unless the worker can establish financial hardship. When determining pre- and post-injury net income, the following apply:

(a) The worker shall provide proof of the worker's pre- and post-injury net income at the insurer's request. The insurer shall not require the worker to provide information about expenditures or family income unless the worker claims a financial hardship.

(b) The insurer shall adjust the worker's pre-injury net income using the cost-of-living matrix as defined in OAR 436-120-0005(2). The insurer shall multiply the pre-injury net income by the factor based on the change in the maximum temporary total disability rate from the date of injury to the date of calculation.

(3) Direct worker purchases shall not include purchases of real property; payment of fines or other penalties; or payment of additional driver's license costs, increased insurance costs or any other costs attributable to problems with the worker's driving record.

(4) In making its decision regarding a direct worker purchase, the insurer may choose the least expensive, adequate alternative. If the worker wants a direct worker purchase which is more expensive than that authorized by the insurer, the worker shall pay the difference in cost.

(5) Within 14 days of its receipt of a request for a direct worker purchase, the insurer shall approve the purchase or inform the worker of its denial in accordance with OAR 436-120-

0610(4).

(6) The insurer shall pay for approved direct worker purchases in time to prevent delay in the provision of services.

(7) Except as provided in section (8) of this rule, the insurer may require the worker to pay for mileage, child or senior care, or for purchases which require the worker to select individual items such as clothing, books and supplies. The insurer shall then reimburse the worker for these costs as follows:

(a) The insurer shall date stamp requests from the worker for reimbursement of the cost of prior approved direct worker purchases upon receipt and shall reimburse the costs within 28 days of receiving the written request and any required supporting documentation.

(b) The insurer shall return denied requests for reimbursement to the worker within 28 days of the insurer's receipt with an explanation of the reason for nonpayment in accordance with OAR 436-120-0610(4).

(8) Should the worker require an advance of any of the costs described in section (7), the insurer shall provide the advance in a timely manner. The worker shall provide information to support the request for advancement of funds.

(9) The insurer shall assign to the worker right and title to the nonexpendable property paid for under this rule and OAR 436-120-0710 as follows:

(a) The insurer shall make such assignment no later than the 60th day of continuous employment unless the worker remains eligible and the suitability of the employment is in question.

(b) The insurer may repossess nonexpendable property if the worker no longer requires the property for training or employment.

(c) The insurer may require repayment of advancements or reimbursements if the worker misrepresented information material to the purchase decision or if the worker used the funds for something other than the approved purchase.

(d) For pre-1986 injuries, OAR 436-120-0730(6) prescribes further conditions for the assignment of repossessed purchases.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.340
Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
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436-120-0710 Direct Worker Purchases: Kinds

The insurer shall provide the direct worker purchases described in sections (1) through (12) of this rule without regard to the worker's pre- or post-injury income except as specifically stated. The insurer shall consider the worker's income as described in OAR 436-120-0700(2) when determining the necessity of the direct worker purchases described in sections (13) through (18) of this rule. The dollar limitations apply to one opening of a claim.

(1) **Tuition, fees, books and supplies for training or studies.** The insurer shall pay the cost in full, subject to the exception in OAR 436-120-0700(4), and shall not require the worker to

apply for grants to pay for tuition, books or other expenses associated with training. The instructional facility, trainer or employer shall identify the items as mandatory. These direct worker purchases pertain to the following:

(a) Training under OAR 436-120-0440 and 0450.

(b) A class necessary to meet the requirements of an available job.

(c) Vocational or academic studies, or basic education for a worker not medically stationary, to enable earlier return to work of a worker not needing training, or earlier completion of training of a worker not yet capable of fully participating in training.

(2) **Wage reimbursement for on-the-job training.** The amount shall be stipulated in a contract between the training employer and the insurer as described in OAR 436-120-0450(1)(b). Such reimbursement is not limited by the fee schedule given in OAR 436-120-0720.

(3) **Travel expenses for transportation, meals and lodging required for participation in vocational assistance**. For the purposes of this section, "participation in vocational assistance" includes, but is not limited to job search, required meetings with the vocational assistance provider, and meetings with employers or at training sites as a required part of the plan or plan development. Travel expenses under this rule do not include expenses related to bringing a worker to within commuting distance of Oregon as discussed in OAR 36-120-0330(4)(a). The conditions and rates for payment of travel expenses are as follows:

(a) Transportation. Costs shall be paid at public transportation rates when public transportation is available. Otherwise, private car mileage for reasonable distances shall be paid at the rate of reimbursement for State of Oregon Workers' Compensation Division classified employees covered under the collective bargaining agreement. Costs incidental to the private car mileage, such as parking fees, also shall be paid. For workers receiving temporary total disability or equivalent income, private car mileage shall be paid only for mileage in excess of the miles the worker traveled to and from work at the time of injury. Mileage payment in conjunction with moving expenses shall be allowed only for one vehicle and for a single one-way trip. To receive reimbursement for private car mileage, the worker must provide the insurer with a copy of the driver's valid driver's license and proof of insurance coverage.

(b) Meals and lodging, overnight travel. For overnight travel, meal and lodging expense shall be reimbursed at the rate of reimbursement for State of Oregon Workers' Compensation Division classified employees covered under the collective bargaining agreement.

(c) Special travel costs. Payment shall be made in excess of the amounts specified in subsections (a) and (b) when special transportation or lodging is necessary because of the physical needs of the worker, or when the insurer finds prevailing costs in the travel area are substantially higher than average.

(4) **Tools and equipment for training or employment.** The items shall be limited to those which are mandatory for the training or initial employment, such as starter sets. Purchases shall not include what the trainer or employer ordinarily would provide to all employees or trainees in the training or employment, or what the worker possesses.

(5) **Moving expenses.** Payment requires that the worker have employment outside

reasonable commuting distance, or that moving is the most feasible and economical way for the worker to participate in training. Payment shall be limited to covering the moving of household goods weighing in total not more than 10,000 pounds and, if necessary, paying reasonable costs of meals and lodging for the worker's family. In determining the necessity of paying moving expenses, the insurer shall consider the availability of employment which does not require moving, or which requires less than the proposed moving distance. Payment for moving expenses is limited to a single one-way trip, unless an exception is made for unusual circumstances. For pre-1986 injuries the exception requires administrative approval.

(6) **Second residence allowance**. The purpose of the second residence must be to enable the worker to participate in training outside reasonable commuting distance. The allowance shall equal the rental expense reasonably necessary, plus not more than $200 a month toward all other expenses of the second residence, excluding refundable deposits. In order to qualify for second residence allowance, the worker must maintain the permanent residence.

(7) **Primary residence allowance**. This allowance shall be limited to first and last months' rent, and requires the worker to have changed residence for training or employment. The last month's rent shall be paid only if this rent is required prior to moving in.

(8) **Medical examinations and psychological examinations for conditions not related to the compensable injury and only for determining the worker's ability to participate in vocational assistance**.

(9) **Physical or work capacities evaluations as defined in the Medical Service Rules, OAR 436-010, when necessary for vocational assistance purposes.**

(10) **Living expense allowance during vocational evaluation**. This allowance requires that the worker be involved in a vocational evaluation at least five hours daily for four or more consecutive days, and not be receiving temporary disability payments. The worker shall not be barred from receiving a living expense allowance if the worker is unable to participate five hours daily because of limitations caused by the injury. The allowance shall equal what the worker would receive for temporary total disability if the worker's claim were reopened.

(11) **Work adjustment, on-the-job evaluation, or situational assessment cost(s).**

(12) **Membership fees and occupational certifications, licenses, and related testing costs**. Payment under this category is limited to $500.

(13) **Clothing required for participation in vocational assistance or for employment.** Purchases shall not include what the trainer or employer would provide or the worker possesses.

(14) **Child or disabled adult care services.** These are payable at rates prescribed by the State of Oregon's Department of Human Resources' Office for Services to Children and Families or Senior and Disabled Services Division, if the services are required to enable the worker to participate in vocational assistance. For workers receiving temporary total disability compensation or equivalent income, these costs shall be paid only when in excess of what the worker paid for such services at the time of injury, adjusted using the cost-of-living matrix as defined in OAR 436-120-0005(2).

(15) **Dental work, eyeglasses, hearing aids and prosthetic devices.** Payment requires

that these be for conditions not related to the compensable injury and for enabling the worker to obtain suitable employment or participate in training.

(16) **Dues and fees of a labor union.** Payment shall be limited to initiation fees, or back dues and one month's current dues.

(17) **Vehicle rental or lease.** This requires that there be no reasonable alternative for enabling the worker to participate in vocational assistance or accept an available job. The worker shall provide the insurer with proof of a valid driver's license and insurance coverage. Payment under this category is limited to $1,000.

(18) **Any other direct worker purchase the insurer considers necessary for the worker's participation as described in the introductory paragraph of this rule.** Payment under this category is limited to $1000.

Stat. Auth.: ORS656.340(9), ORS656.726(3)
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436-120-0720 Fee Schedule and Conditions for Payment of Vocational Assistance Costs

The maximum amounts the insurer may spend for all activities normally associated with each category of assistance, except where the insurer determines the case warrants exceeding the limit, are included in this fee schedule and apply to one opening of a claim. These limits are set at a level adequate to provide necessary services for the vast majority of workers and do not represent an entitlement for any individual worker. The department will adjust these figures annually using the cost-of-living matrix defined in OAR 436-120-0005(2).

(1) Limits on professional costs, including travel/wait and other travel expenses, to determine whether the worker is eligible for vocational assistance using the criteria given in OAR 436-120-0320, 0330, 0340 and 0350: $808

(2) Limits on professional costs, including travel/wait and other travel expenses, for the following categories of assistance:

(a) Vocational evaluation, as described in OAR 436-120-0400(1): $1,010

(b) Direct employment, as described in OAR 436-120-0400(2), including related services such as Reemployment Assistance Program negotiations: $3,636

(c) Training, as described in OAR 436-120-0400(3), including related services such as job placement after training, return-to-work follow-up, and Reemployment Assistance Program negotiations: $9090

(d) A combination of direct employment and training: $10,100

(3) Limits on professional costs for participation, as required by the insurer or the division, in the dispute resolution process: $303

(4) Direct worker purchases, described in OAR 436-120-0700 and 0710, as necessary for:

(a) Vocational evaluation, as described in OAR 436-120-0400(1): $808

(b) Direct employment, as described in OAR 436-120-0400(2): $1,818

(c) Training, as described in OAR 436-120-0400(3): $10,908

(d) Wage reimbursement for on-the-job training contracts, subject to the conditions described in OAR 436-120-0450(1) and 0710(2), and the living expense allowance during vocational evaluation, subject to conditions described in OAR 436-120-0710(10), are not covered by the fee schedule.

(5) Services and direct worker purchases provided after the end of eligibility as necessary to complete a plan or to secure a job located during the eligibility period shall be billed as part of the last fee schedule category prior to closure.

(6) Additional limits relating to reimbursement of vocational assistance costs for pre-1986 injuries are described in OAR 436-120-0730.

(7) In accordance with ORS 656.258, if the insurer assigns a worker to a vocational assistance provider for a determination of eligibility or vocational assistance services, the insurer shall pay, within 60 days of receipt, the provider's billing duly rendered under the agreement between the insurer and the provider. The insurer shall not deny payment on the grounds the worker was not eligible for the assistance if the provider performed the services in good faith without knowledge of the ineligibility.

(8) The insurer shall pay the provider for the development of a plan which the insurer approved even if the division finds the plan to be nonconforming, unless the provider misrepresented material information.

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436-120-0730 Reimbursement of Vocational Assistance Costs for Pre-1986 Injuries

(1) This rule applies only to pre-1986 injuries, and carries out the provisions of section 15, chapter 600, Oregon Laws 1985. A reference to "pre-1986 injuries" relates to injuries sustained before January 1, 1986, and encompasses both original claims and claims for aggravation of such injuries.

(2) The department will reimburse insurers for costs of vocational assistance for eligible workers with respect to pre-1986 injuries only. Reimbursement is subject to the availability of funds.

(3) The following kinds of reimbursements are the only kinds allowable under these rules:

(a) Direct worker purchases under OAR 436-120-0700 and 0710, including necessary

costs of repossession.

(b) Charges for services provided to eligible workers by vocational assistance providers selected in accordance with OAR 436-120-0370.

(c) Temporary disability compensation as provided in OAR 436-120-0750.

(d) Wages the insurer has subsidized under on-the-job training contracts as described in OAR 436-120-0450(1)(b).

(e) Dispute resolution participation as described in OAR 436-120-0720(3).

(4) The following are requirements for reimbursement of vocational assistance costs:

(a) The vocational assistance was provided in accordance with ORS chapter 656 and these rules.

(b) The vocational assistance provider was appropriately authorized under OAR 436-120-0800, and the providing staff had the appropriate certifications under OAR 436-120-0810 and 0830.

(c) The insurer authorized the vocational assistance and, before requesting the reimbursement, obtained any required administrative approvals.

(d) The insurer received any necessary waiver(s) under OAR 436-120-0003(6) prior to providing the assistance and requesting reimbursement.

(e) The insurer's request for reimbursement is accompanied by the supporting billing reports of the vocational assistance provider and, unless otherwise prescribed by the director, the supporting vocational progress reports. These reports shall be in the form prescribed by the director, shall provide information on the worker's vocational progress since the previous report, and shall document the categories and kinds of services, amounts of time spent, costs paid for direct worker purchases, and charges of the provider, as well as other relevant information prescribed by the director. Requests for reimbursement shall be made in the manner prescribed by the director. Reimbursement to any particular insurer will be no less often than once in each calendar quarter. This subsection does not apply to reimbursement under OAR 436-120-0750 of temporary disability compensation.

(f) Costs exceeding the fee schedule under OAR 436-120-0720 shall be reimbursed only with administrative approval. An administrative approval under this subsection will be based on whether the costs exceeding the fee schedule were necessary and not unreasonably high under the circumstances. This subsection does not apply to reimbursement under OAR 436-120-0750 of temporary disability compensation, wage reimbursement for on-the-job training, or the living expense allowance during vocational evaluation.

(g) The department will reimburse for travel expenses for transportation, meals and lodging of vocational assistance staff in connection with providing vocational assistance. The conditions and rates for reimbursement are as follows:

(A) Transportation. Private car mileage will be reimbursed at the rate of reimbursement for State of Oregon Workers' Compensation Division classified employees covered under the collective bargaining agreement. Costs incidental to the private car mileage, such as parking fees,

will also be reimbursed. Travel by commercial carrier will be reimbursed if justified by lower overall cost or other factors.

(B) Meals and lodging. Expenses for non-overnight travel will not be reimbursed. For overnight travel, meal and lodging expense will be reimbursed at the rate of reimbursement for State of Oregon Workers' Compensation Division classified employees covered under the collective bargaining agreement.

(h) The insurer shall request reimbursement only of those costs which the insurer has paid. The insurer shall not charge reimbursed costs to the insured employer as claim costs or by any other means. Insurer reimbursement requests before the insurer has paid the respective costs are subject to department denial or recovery, in addition to any penalties under ORS chapter 656 and these rules. The insurer's payment check issued within reasonable time for the insurer's internal processing after the payment authorization will be considered payment as of the time of the authorization.

(5) Further procedures and conditions relating to reimbursement for direct worker purchases are as follows:

(a) If the cost for a single item is over $2,500, the insurer shall obtain three competitive quotes and shall normally select the lowest quote. If three quotes are not available, the insurer shall document efforts to obtain three quotes (i.e., sole source).

(b) The insurer shall not issue multiple orders to circumvent the requirements of this section.

(6) The insurer shall retain right and title to the nonexpendable property paid for under this rule for the period of time the insurer considers necessary to determine the success of the vocational assistance, normally 60 days of continuous suitable employment. At the end of that period, the insurer shall either assign the right and title to the worker if the worker is working in the occupation for which the insurer provided the property, or repossess the property. The following procedures and conditions apply with respect to nonexpendable property paid for under this rule:

(a) The insurer shall, if feasible, reassign repossessed property to another worker eligible for the property; or, may transfer the property to another insurer for such reassignment. Each insurer shall maintain documentation of such transfers for audit purposes, including the estimated value of the property. Unless so reassigned, the insurer shall sell the property within six months and transmit the proceeds promptly to the department. If property to which the insurer holds title suffers an insured loss, the insurer shall transmit the insurance proceeds promptly to the department.

(b) If the worker fails to meet the conditions prescribed by the insurer for the care and protection of property in the worker's custody, and the property suffers damage or loss, the division will not reimburse for its replacement.

(7) Under ORS 656.593, if the worker or the worker's beneficiaries recover damages from the employer or a third person, the proceeds are subject to lien by the department and recovery of its share of any reimbursements made to the insurer under these rules.

(8) The insurer shall submit all reimbursement requests no later than one year after the date of service. The department will not reimburse requests submitted after that date unless the insurer can show good cause for the late submission.

(9) All reimbursements are subject to department audits as described in OAR 436-120-0900 within five years of the last request for reimbursement, and may be disallowed on any of the grounds set forth in these rules. The department may recover disallowed reimbursements directly or may deduct from future reimbursements.

(10) An insurer aggrieved by a department decision under this rule may request a hearing in accordance with ORS 656.704(2), ORS Chapter 183, and OAR 436-120-0008(3).

Stat. Auth.: ORS 656.726(3)
Stat. Impltd.: Section 15, chapt. 600, Oregon Laws 1985, ORS 656.340
Hist: Filed 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temp.)
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-300, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/87
Amended and Renumbered from OAR 436-120-220 and 255, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff 3/1/96

436-120-0740 Temporary Disability Compensation During Training

(1) OAR 436-030 and OAR 436-060, in addition to this rule, apply to payment of awards for permanent disability and payment of temporary disability compensation.

(2) Workers injured after December 31, 1973, are entitled to temporary disability compensation from the insurer while enrolled and actively engaged in training under these rules. For the purposes of claim closure under ORS 656.268 and OAR 436-030, training will be considered to have ended when the worker has completed 21 months of training, even if expenses associated with training are paid for a longer period as described in OAR 436-120-0440(4).

Stat. Auth.: ORS 656.726(3)
Stat. Impltd.: ORS 656.268, ORS 656.340
Hist: Filed 12/20/73 as WCD Admin. Order 6-1973, eff. 1/11/74
Amended 11/5/74 as WCD Admin. Order 45-1974, eff. 11/5/74 (Temp.)
Amended 2/5/75 as WCD Admin. Order 4-1975, eff. 2/26/75
Amended 3/29/77 as WCD Admin. Order 3-1976, eff. 4/1/76
Amended 9/29/77 as WCD Admin. Order 3-1977, eff. 10/4/77 (Temp.)
Amended 2/1/78 as WCD Admin. Order 1-1978, eff. 2/1/78
Amended 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-410, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-230, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96

436-120-0750 Reimbursement of Temporary Disability Compensation Costs for Pre-1986 Injuries

(1) This rule applies only to pre-1986 injuries, and carries out the provisions of section

15, chapter 600, Oregon Laws 1985.

(2) Subject to all of the conditions of these rules, the department will reimburse an insurer for the net amount of sums paid in accordance with these rules as temporary disability compensation to a worker during the time enrolled and actively engaged in training after the date the worker became medically stationary.

(3) The insurer shall make application to the department at the end of each calendar quarter for reimbursement under this rule. The department will approve the application and reimburse funds after deducting amounts owed the department, if:

(a) The insurer provided training in accordance with these rules; and

(b) The net amount of compensation paid is verifiable upon department audit.

(4) The department may reimburse an insurer for unrecovered overpayments if the insurer has made a timely effort to recover the overpayments as provided in OAR 436-120-0740 unless the overpayments resulted from the insurer's failure to monitor the training status of the worker. If the insurer recovers an overpayment after reimbursement, the insurer shall repay the department to the extent of the recovery.

(5) Whenever the department denies reimbursement, the insurer shall not charge the costs of temporary disability compensation to the insured employer by means of assessment, increased premium or change in classification or experience rating, or by any other means.

(6) An insurer aggrieved by a department decision under this rule may request a hearing in accordance with ORS 656.704(2), ORS chapter 183 and OAR 436-120-0008(3).

Stat. Auth.: ORS 656.704(2), ORS 656.726(3)
Stat. Impltd.: Section 15, chapt. 600, Oregon Laws 1985; ORS 656.268; ORS 656.340; ORS 656.704(2); ORS chapt. 183
Hist: Filed 12/20/73 as WCD Admin. Order 6-1973, eff. 1/11/74
Amended 11/5/74 as WCD Admin. Order 45-1974, eff. 11/5/74 (Temp.)
Amended 2/6/75 as WCD Admin. Order 4-1975, eff. 2/26/75
Amended 3/29/76 as WCD Admin. Order 1-1976, eff. 4/1/76
Amended 9/29/77 as WCD Admin. Order 3-1977, eff. 10/4/77 (Temp.)
Amended 2/1/78 as WCD Admin. Order 1-1978, eff. 2/1/78
Amended 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-430, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-250, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95

436-120-0800 Authorization of Vocational Assistance Providers: Requirements

(1) A vocational assistance provider must be authorized by the director under this rule. To be authorized by the director, the provider must submit an application which includes an explanation of how it plans to supervise and train its staff; a staff roster which verifies that each of its vocational assistance staff providing services under these rules is certified by the director under OAR 436-120-0830; and evidence it meets applicable state and federal requirements.

(2) The authorization will limit the provider to the provision of specific services, as determined by its staff's certifications. The director is not obligated to look beyond the completed application and the department's certification records to approve, deny or continue authorization.

(3) Those seeking authorization as a vocational assistance provider shall be limited to two attempts to have an application for authorization approved by the division. The division shall not accept further applications for authorization for one year after the date of decision on the second unsuccessful application.

(4) Vocational assistance providers shall comply with the following in order to maintain authorization under this rule:

(a) Maintain on file with the division a current roster of certified staff which includes staff certification numbers;

(b) Notify the division within 30 days of any changes in office address, telephone number, contact person or staff;

(c) Meet applicable state and federal requirements;

(d) Adequately train and supervise certified staff;

(e) Provide each certified staff person with department rules, bulletins, and other information, as prescribed by the director.

(5) Vocational assistance providers must apply for continuation of authorization before the expiration date of existing authorization, as prescribed by the director. The division must receive the application at least 30 days before the expiration date. Denial of continuation of an authorization will be considered revocation. The notice of revocation will specify under what conditions, if any, the provider may reapply for authorization.

(6) Vocational assistance providers whose authorization is denied or revoked under this rule may appeal as described in OAR 436-120-0008(5).

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.340
Hist: Filed 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82.
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Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
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Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
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Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96

436-120-0810 Certification of Individuals: Requirements

Individuals determining workers' eligibility and providing vocational assistance shall be certified by the director and shall be on the staff of an authorized vocational assistance provider, insurer, or self-insured employer.

(1) An applicant for certification shall complete an application, as prescribed by the director, which shows the applicant meets the qualifications for a specific classification of certification. The director is not obligated to look beyond the completed application and department certification records to approve or deny certification.

(2) Individuals making an initial application for certification as a Vocational Rehabilitation Counselor must meet the qualifications of OAR 436-120-0830(1).

(3) Department certification is not required to perform work evaluations, but the work evaluator must be certified by the professional organizations described in OAR 436-120-0420(2).

(4) To maintain Vocational Rehabilitation Counselor certification, the individual shall acquire a minimum of 20 hours of continuing education units as described in OAR 436-120-0820 within two years from the effective date of certification and every two years thereafter. At least three of the hours must be department provided instruction in the requirements of OAR 436-120. Additional credit will not be allowed if an individual repeats the same certified continuing education program, unless the program material differs substantially from first attendance; or the program includes legislative or rule changes. Failure to meet the requirements of this section shall cause a Vocational Rehabilitation Counselor's certification to expire. Such an individual may reapply for certification upon completion of the required 20 hours of continuing education.

(5) Individuals whose certification is denied under this rule may appeal as described in OAR 436-120-0008(5).

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.340
Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-205, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin Order 95-074, eff. 3/1/96

436-120-0820 Continuing Education

(1) The department will grant continuing education units for courses approved by the Commission on Rehabilitation Counselor Certification (CRCC) or the Certified Insurance Rehabilitation Specialist Commission (CIRS); courses in or related to psychology, sociology, counseling, and vocational rehabilitation, if given by an accredited institution of higher learning; training presented by the department pertaining to OAR 436-120 and OAR 436-110; and any continuing education program certified by the department under OAR 436-055. Each clock hour will count as one unit, except as noted in section (3) of this rule.

(2) Of the 20 continuing education units required every two years under OAR 436-120-0810(4), at least three hours shall be department presented training pertaining to OAR 436-120. No more than ten hours shall be from continuing education programs certified under OAR 436-055.

(3) In the case of college course work, the department will grant credit only for grades of C or above and will multiply the number of credit hours by six to establish the number of continuing education units.

(4) The certified individual shall submit proof of completion of college, CRCC, and CIRS courses to the department no later than 30 days prior to the recertification date. Certificates of attendance including the number of hours of training completed and transcripts including the number of credit hours completed will be considered proof of completion.

(5) Trainers providing continuing education under OAR 436-055 shall submit a list of those who satisfactorily complete training as required under that rule.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.340
Hist: Filed 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff 3/1/96

436-120-0830 Certification of Vocational Assistance Staff: Categories

The categories, qualifications and conditions of certification are as follows:

(1) Vocational Rehabilitation Counselor certification, which allows the individual to provide all eligibility determination and vocational assistance services including vocational testing if qualified under OAR 436-120-0420(1)(a) and work evaluation if qualified under OAR 436-120-0420(2). Vocational Rehabilitation Counselor certification requires:

(a) Accreditation as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification; or

(b) Accreditation as a Certified Insurance Rehabilitation Specialist (CIRS) by the Certified Insurance Rehabilitation Specialist Commission; or

(c) A master's degree in vocational rehabilitation counseling and at least six months of direct experience; or

(d) A master's degree in psychology, counseling, or a field related to vocational rehabilitation, and 12 months of direct experience; or

(e) A bachelor's or higher degree and 24 months of direct experience. Thirty- six months of direct experience may substitute for a bachelor's degree.

(2) Vocational Rehabilitation Intern certification, which allows an individual who does not meet the requirements for certification as a Vocational Rehabilitation Counselor the opportunity to gain the required experience. Vocational Rehabilitation Intern certification requires a bachelor's degree in psychology, counseling, or a field related to vocational rehabilitation; or a bachelor's degree and 12 months of direct experience. Thirty-six months of direct experience may substitute for a bachelor's degree. The Vocational Rehabilitation Intern certification is subject to the following conditions:

(a) The intern must be supervised by a certified Vocational Rehabilitation Counselor who shall co-sign and assume responsibility for all the intern's eligibility determinations, vocational evaluations, return-to-work plans, vocational and billing reports.

(b) When the intern has met the experience requirements, the intern may apply for certification as a Vocational Rehabilitation Counselor.

(3) Return-to-Work Specialist certification, which allows the person to provide job search skills instruction; job development; return-to-work follow-up and labor market survey; and to determine eligibility for vocational assistance, except where such determination requires a judgment as to whether the worker has a substantial handicap to employment. This certification requires 24 months of direct experience. Full-time (or the equivalent) additional college coursework in psychology, counseling, or a field related to vocational rehabilitation may substitute for up to 18 months of direct experience, on a month-for-month basis.

(4) To meet the direct experience requirements for Vocational Rehabilitation Counselor, the individual must:

(a) Perform return-to-work plan development and implementation for the required number of months; or

(b) Perform three or more of the qualifying job functions listed in paragraphs (A) through (J) of this subsection for the required number of months, with at least six months of the experience in one or more of functions listed in paragraphs (A) through (D) of this subsection. The qualifying job functions are:

(A) Return-to-work plan development and implementation;

(B) Employment counseling;

(C) Job development as described in OAR 436-120-0430(1)(c);

(D) Early return-to-work assistance which must include working directly with workers and their employers;

(E) Vocational testing as described in OAR 436-120-0420(1);

(F) Job search skills instruction as described in OAR 436-120-0430(1)(b);

(G) Job analysis as described in OAR 436-120-0420(6);

(H) Transferable skills assessment or employability evaluations;

(I) Return-to-work plan review and approval; or

(J) Employee recruitment and selection for a wide variety of occupations.

(5) To meet the direct experience requirements for Vocational Rehabilitation Intern or Return-to-Work Specialist, the individual must:

(a) Perform return-to-work plan development and implementation for the required number of months; or

(b) Perform three or more of the qualifying job functions listed in paragraphs (4)(b)(A) through (J) of this rule for the required number of months.

(6) To receive credit for direct experience, the individual must:

(a) Perform one or more of the qualifying job functions listed in paragraphs (4)(b)(A) through (J) of this rule at least 50 percent of the work time for each month of direct experience credit. Qualifying job functions performed in a job which is less than full time shall be prorated. For purposes of this rule, full time shall be 40 hours a week. An individual will not receive credit for any function performed less than 160 hours.

(b) Provide any documentation required by the director, including work samples. The director may also require verification by the individual's past or present employers.

(7) Certification to administer certain vocational tests may require independent authorization by the appropriate bodies. Such certification or authorization is independent from the categories of certification in this rule.

(8) All degrees must be from accredited institutions and documented by a copy of the transcript(s) with the application for certification.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.340
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Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96

436-120-0840 Professional Standards for Authorized Vocational Assistance Providers and Certified Individuals

(1) Authorized vocational assistance providers and certified individuals shall:

(a) Meet authorization requirements under OAR 436-120-0800 or certification requirements under OAR 436-120-0810 and 0830;

(b) Determine eligibility and provide assistance in an objective manner not subject to any conditions other than those prescribed in these rules;

(c) Fully inform the worker of the categories and kinds of vocational assistance available under these rules and reemployment assistance available under OAR 436-110;

(d) Document all case activities in legible file notes or reports;

(e) Maintain file notes or reports in accordance with OAR 436-120-0620(5) and provide this information to the department in accordance with OAR 436-120-0620(1);

(f) Provide only vocationally relevant information about workers in written and oral reports;

(g) Recommend workers only for suitable employment;

(h) Fully inform the worker of the purpose and results of all testing and evaluations;

(i) Fully participate in any department audit, investigation or review, and provide records and other information as requested; and

(j) Comply with generally accepted standards of conduct in the vocational rehabilitation profession.

(2) Authorized vocational assistance providers and certified individuals shall not:

(a) Provide evaluations or assistance if there is a material conflict of interest or relevant and material prejudice concerning the worker;

(b) Enter into any relationship with the worker to promote personal gain, or the gain of a person or organization in which the vocational assistance provider or certified individual has an interest;

(c) Engage in, or tolerate, sexual harassment of a worker. "Sexual harassment" means deliberate or repeated comments, gestures or physical contact of a sexual nature;

(d) Violate any applicable state or federal civil rights law;

(e) Commit fraud or misrepresentation in connection with an application for authorization or certification, report or return-to-work plan, or the vocational assistance activities or responsibilities of a vocational assistance provider under these or other rules of the department, or in connection with a comparable program in another jurisdiction;

(f) Make a serious error or omission in connection with an application for authorization or certification, report or return-to-work plan, or the vocational assistance activities or responsibilities of a vocational assistance provider under these or other rules of the department;

(g) Engage in collusion to withhold information, or submit false or misleading information relevant to the determination of eligibility or provision of vocational assistance;

(h) Engage in collusion to violate these rules or other rules of the department, or any policies, guidelines or procedures issued by the director;

(i) Fail to comply with an order by the director to provide specific vocational assistance, except as provided in ORS 656.313;

(j) Instruct any individual to make decisions or engage in behavior which is contrary to the requirements of these rules.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.313, ORS 656.340
Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88g
Amended and Renumbered from OAR 436-120-207, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95

436-120-0850 Sanctions of Authorized Vocational Assistance Providers and Certified Individuals

(1) For the purpose of this rule, the director may take one or more of the following actions against an authorized vocational assistance provider or certified individual for violations of OAR 436-120-0840 using the criteria given in section (2) of this rule:

(a) Denial of authorization or certification.

(b) Reprimand.

(c) Probation, in which the department systematically monitors the provider's or individual's compliance with the professional standards under OAR 436-120-0840 for a specified length of time. Probation may include the requirement an individual receive supervision, or successfully complete specified training, personal counseling or drug or alcohol treatment.

(d) Suspension, which is the termination of authorization or certification to determine eligibility and provide vocational assistance to Oregon injured workers for a specified period of time. The provider or individual may reapply for authorization or certification at the end of the suspension period. If granted, the provider or individual will be placed on probation as described in subsection (c) of this rule.

(e) Revocation, which is a permanent termination of authorization or certification to determine eligibility and provide vocational assistance to Oregon injured workers.

(2) In determining the appropriate sanction(s), the director shall consider all relevant circumstances, including, but not limited to:

(a) The degree of harm inflicted on the worker, employer, insurer, other vocational assistance provider or certified individual, or department;

(b) Whether there have been previous violations; and

(c) Whether there is evidence of intentional violation. "Intentional" means the vocational assistance provider or certified individual consciously engaged in non-professional conduct as described in OAR 436-120-0840.

(3) The director shall investigate violations of OAR 436-120-0840 and may impose a

sanction under these rules. Before imposing a sanction, the director shall send a notice of the proposed action and provide the opportunity for a show-cause hearing. The process is as follows:

(a) The director shall send by certified mail a written notice of intended sanction and the grounds for such action. The notice shall advise of the right to participate in a show-cause hearing.

(b) The vocational assistance provider or individual has ten days from the date of receipt of the notification of proposed action in which to request a show-cause hearing.

(c) If the vocational assistance provider or individual does not request a show-cause hearing, the proposed sanction shall become final.

(d) If the vocational assistance provider or individual requests a show-cause hearing, the director shall send a notification of the date, time and place of the hearing.

(e) After the show-cause hearing, the director shall issue a final order which may include any sanction(s) described in section (1) of this rule or may dismiss any or all of the allegation(s). An order under this section may be appealed as described in OAR 436-120-0008(5).

(4) The director may bar a provider or individual sanctioned under this rule from sponsoring or teaching claims' examiner continuing education programs certified under OAR 436-055. A provider or individual whose authorization or certification has been revoked is automatically precluded from sponsoring or teaching such programs.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)
Stat. Impltd.: ORS 656.340
Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
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436-120-0900 Audits, Penalties and Sanctions

(1) Insurers, employers at injury, vocational assistance providers and certified individuals are subject to periodic program and fiscal audits by the department. If, through audit or investigation, the director finds the insurer, employer at injury, provider or a certified individual failed to comply with these rules, the director may take one or more corrective actions including, but not limited to:

(a) Recovery of reimbursements.

(b) Denial of reimbursement requests.

(c) Sanctions or civil penalties against insurers or employers as described in sections (2) through (5) of this rule.

(d) Sanctions against vocational assistance providers and certified individuals as described in OAR 436-120-0850.

(2) Insurers or employers at injury who fail to comply with a director's order in accordance with the requirements of OAR 436-120-0008 may be assessed civil penalties as follows:

	Number of Violations in Calendar Year				
	1	**2**	**3**	**4**	**5+**
Days Late					
1 to 7	$ 100	$ 200	$ 300	$ 500	$ 1,000
8 to 14	200	300	500	1,000	2,000
15 to 21	300	500	1,000	2,000	2,000
22+	500	1,000	2,000	2,000	2,000

(3) An insurer may be assessed a civil penalty of up to $2000 for violation of OAR 436-120-0008(1), 120-0300, 120-0320, 120-0340, 120-0350, 120-0360, 120-0370, 120-0400, 120-0410, 120-0420, 120-0430, 120-0440, 120-0450, 120-0460, 120-0500, 120-0510, 120-0520, 120-0530, 120-0600, 120-0610, 120-0620, 120-0700, 120-0710, 120-0720, 120-0730, 120-0740, 120-0750, 120-0800, 120-0810, 120-0830, or 120-0840. When assessing penalties under this section, the director may take into consideration whether violation(s) were intentional or repeated. For the purposes of this section:

(a) "Intentional" means the insurer or employer acted with a conscious objective to cause any result described in ORS 656.745(1) and (2) or to engage in the conduct so described in those sections.

(b) "Repeated" means more than once in a twelve month period.

(4) Insurers or employers at injury who fail to provide requested materials as set forth in OAR 436-120-0620 and 120-0008(1) may be assessed penalties in accordance with the "Matrix for Assessing Penalties," under OAR 436-060. "Days Late" shall be counted beginning the next working day following the request deadline date through the last working date prior to the department's "received date."

(5) Pursuant to ORS 656.447, the director may suspend or revoke an insurer's authority to issue guaranty contracts upon determination that the insurer has failed to comply with these rules.

Stat. Auth.: ORS 656.340, ORS 656.726(3)
Stat. Impltd.: ORS 656.340, ORS 656.447, ORS 656.745(1) and (2)
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Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-255 and 270, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95

436-120-0910 Optional Services

Optional services are services provided to an ineligible worker or services in excess of those described in these rules provided to an eligible worker. Such services are at the discretion of an insurer.

(1) Optional services are not subject to department audit or review and are not reimbursable under OAR 436-120-0730 and 0750.

(2) The insurer shall not use optional services to circumvent the intent of these rules.

(3) When providing optional services to an ineligible worker other than those related to the return to work of a nonmedically stationary worker with the employer at injury, the insurer shall notify the worker. The notice of optional services shall clearly state the worker's vocational eligibility status under these rules. The notice shall state that optional services are not subject to review by the Workers' Compensation Division and shall include the following language:

"If you have questions about your eligibility for vocational assistance, you may contact the Workers' Compensation Division's toll free number, (use appropriate telephone number.)"

Stat. Auth.: ORS 656.726(3)
Stat. Impltd.: ORS 656.340
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