ORS 656.325 (1)(a),(f)
OAR 436-060-0095 Suspension Checklist

Chapter 436, Division 060, Claims Administration, effective July 1, 2024

FAILURE TO ATTEND OR TO COOPERATE WITH AN IME

Claimant_____Claim Number_____

Claim status:_____Deferred_____Accepted _____Denied_____Partial Denial

IME APPOINTMENT LETTER

1. _____ IME examiner chosen from director's list ***OAR 436-010-0265(1)(c)***

2. _____ On insurer stationery if party other than insurer schedules exam ***OAR 436-060-0095(3)(c)***

3. _____ Worker notified in writing; appointment notice sent at least 10 days before exam ***0095(3)(a) and (b)***

4. _____ If represented, worker's attorney simultaneously notified in writing ***0095(3)(a)***

5. _____ Name of the examiner or the facility ***0095(3)(e)(A)***

6. _____ Statement of specific purpose for exam and identification of medical specialties of examiners ***0095(3)(e)(B)***

7. _____ Date, time, and place of exam ***0095(3)(e)(C)***

8. _____ First and last name of attending physician (AP) or authorized nurse practitioner (ANP) and verification AP or ANP is being informed of the exam by at least a copy of the appointment letter, OR a statement that there is no AP or ANP ***0095(3)(e)(D)***

9. _____ If applicable, confirmation that the director has approved the examination ***0095(3)(e)(E)***

10. _____ A statement that reasonable costs for transportation and, if necessary, child care, meals, lodging, and other related services will be reimbursed with receipts or other evidence necessary to support request ***0095(3)(e)(F)***

11. _____ Offer advance of funds and that a request must be made in sufficient time to assure attendance at exam ***0095(3)(e)(F)***

12. _____ A statement that an amount equivalent to net lost wages will be paid for absence from work necessary to attend exam if temporary disability is not received under ORS 656.210(4) ***0095(3)(e)(G)***

13. _____ A statement that the worker has the right to have an observer present at the exam, but the observer may not be compensated in any way for attending the exam. If the exam is psychological, the observer is allowed only if the examining provider approves the presence of an observer ***0095(3)(e)(H)***

14. _____ The warning paragraph in bold and formatted as follows ***0095(3)(e)(I)(ii)****

You must attend this examination. If there is any reason you cannot attend, you must tell us as soon as possible before the date of the examination.

If you disagree with the location of this appointment, you must contact the Workers' Compensation Division at 800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice.

Your workers' compensation benefits may be suspended under Oregon laws and rules* if you:

- Do not attend the examination,

- Do not have a good reason for not attending the examination, or

- Do not cooperate with the examination.

You may be charged a $100 penalty if you do not attend the examination without good reason or if you do not notify the insurer before the examination. The penalty is taken out of future benefits.

If you have any questions you may call:

- [Insurer] at [Insurer phone number]
- Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585
- Ombuds Office for Oregon Workers at 800-927-1271 (toll-free)

***Oregon Revised Statute 656.325 and Oregon Administrative Rules, Chapter 436, division 60**

15. _____ Include the following with the IME appointment notice sent to the worker ***0095(3)(d)***:
- A copy of a reimbursement request form ***0095(3)(d)(A)***
- Director's brochure "Important Information about Independent Medical Exams" ***0095(3)(d)(B)***

SUSPENSION REQUEST

1. _____ Copy of the suspension request, including all attachments, sent certified, registered, or by personal service to the worker ***0095(6)***

2. _____ If represented, a copy of the suspension request, including all attachments, simultaneously sent certified, registered, or by personal service to the worker's attorney ***0095(6)***

3. _____ A statement that the insurer requests suspension of compensation under ORS 656.325 and OAR 436-060-0095 ***0095(6)(a)***

4. _____ Identify the claim status and any accepted or newly claimed conditions ***0095(6)(b)***

5. _____ Describe the worker's specific actions that prompted the request ***0095(6)(c)***

6. _____ Dates of prior IMEs the worker has attended for the current open period of this claim and the names of examining physicians or facilities OR a statement that there have been no prior IMEs ***0095(6)(d)***

7. _____ A copy of any approval given by the director OR a statement that approval was not necessary ***0095(6)(e)***

8. _____ Any reason given by the worker or the worker's representative for failure to comply OR a statement that no reason has been provided ***0095(6)(f)***

9. _____ The date and with whom the failure to comply was verified. Written verification of the worker's refusal to attend exam received from worker or worker's attorney is sufficient to request suspension ***0095(6)(g)***

   e.g., "On_____(date)_____(name) at_____(facility) verified the worker did not attend." OR "On_____(date)_____(insurer) received written verification from _____(worker or attorney) stating that the worker would not be attending the exam."

10. _____ A copy of the IME notice of appointment letter and a copy of any written refusal to attend received from the worker or worker's attorney ***0095(6)(h)***

11. _____ Any other supporting information that supports suspension request ***0095(6)(i)***

12. _____ The notice to worker in bold and formatted as follows ***0095(6)(j)(B)****

Notice to worker:

If the Workers' Compensation Division grants this request, you may lose all or part of current or future benefits.

If you think this request to suspend your compensation is wrong, write to the Workers' Compensation Division immediately.

- Your letter must be mailed within 10 days of the date this request was mailed or personally served on you.

- Address your letter to:

Workers' Compensation Division
350 Winter Street NE
PO Box 14480
Salem OR 97309-0405

If you have any questions, you may call the Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585.

*The mandatory language in this checklist must be used no later than Oct. 1, 2024. See OAR 436-060-0095(3)(e)(I) and OAR 436-060-0095(6)(j) for more information.