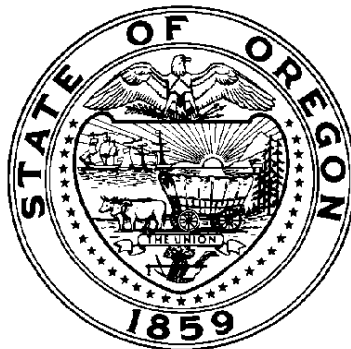


Oregon Administrative Rules

Chapter 436

**Oregon Department of Consumer and Business Services
Workers' Compensation Division**

April 1, 2025



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OREGON ADMINISTRATIVE RULES

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PLEASE NOTE: This is a complete compilation of chapter 436 of the Oregon Administrative Rules as of April. 1, 2025. Please contact the Workers' Compensation Division to find out about recently issued rules (with future effective dates), or visit the division's "New rules" webpage: <https://wcd.oregon.gov/laws/Pages/new-rules.aspx>.

HISTORY LINES: These rules include only the most recent "History" lines. The history line shows when the rule was last revised and its effective date. To obtain a comprehensive history for OAR chapter 436, please visit the division's website:

https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

**OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
PROCEDURAL RULES, ATTORNEY FEES, AND GENERAL PROVISIONS**

**Administrative
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**CHAPTER 436, DIVISION 001
OREGON ADMINISTRATIVE RULES**

**PROCEDURAL RULES, RULEMAKING, HEARINGS,
AND ATTORNEY FEES**

Effective September 1, 2022

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436-001-0003 Purpose and Applicability of these Rules

(1) Rules related to rulemaking.

OAR 436-001-0005 through 436-001-0009 establish supplemental procedures for rulemaking under ORS chapter 183 and apply to all division rulemaking on or after the date the rules are effective.

(2) Rules related to hearings.

OAR 436-001-0019 through 436-001-0296 establish supplemental procedures for hearings on matters within the director's jurisdiction.

(a) In general, the rules of the Workers' Compensation Board in OAR chapter 438 apply to the conduct of hearings, unless these rules provide otherwise.

(b) Except for OAR 436-001-0030, these rules do not apply to hearings requested under ORS 656.740.

(c) These rules do not apply to hearings on reconsideration orders issued under ORS 656.268.

(d) These rules apply to hearings held on or after the date the rules are effective.

(3) Rules related to attorney fees.

OAR 436-001-0400 through 436-001-0440 apply to attorney fees under ORS 656.262(11) and (12), 656.268(6)(c), 656.277(1)(b), 656.383(1), and 656.385(1). These rules apply to orders issued on or after the date the rules are effective, regardless of the date the claim was filed or closed.

(4) General provisions.

OAR 436-001-0500 applies to any refund or credit processed by the director on or after the date the rule is effective, regardless of the date the payment was received.

(5) Procedural waiver.

The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.262, 656.268, 656.277, 656.383, 656.385, 656.704, ORS ch. 183

Hist: Amended 7/5/22 as WCD Admin. Order 22-061, eff. 9/1/22

436-001-0004 Definitions

(1) Unless a term is defined in these rules or the context otherwise requires, the definitions of ORS chapter 656 and ORS 183.310 are incorporated by reference and made a part of these rules.

(2) For the purpose of these rules:

(a) **"Administrative law judge"** means an administrative law judge appointed by the Workers' Compensation Board, as defined in OAR 438-005-0040.

(b) **"Board"** means the Workers' Compensation Board and includes its Hearings Division.

(c) **"Delivered"** means physical delivery to the division's Salem office during regular business hours.

(d) **"Director"** means the director of the Department of Consumer and Business Services or the director's designee.

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(e) “**Division**” means the Workers’ Compensation Division of the Department of Consumer and Business Services.

(f) “**Filed**” means mailed, faxed, emailed, delivered, or otherwise submitted to the division in a method allowable under these rules.

(g) “**Final order**” means a final, written action of the director.

(h) “**Mailed**” means addressed to the last known address, with sufficient postage and placed in the custody of the U.S. Postal Service.

(i) “**Party**” refers to a party to the hearing and may include, but is not limited to, a worker, an employer, an insurer, a self-insured employer, a managed care organization, a medical provider, or the division.

(j) “**Proposed and final order**” means an order subject to revision by the director that becomes final unless exceptions are timely filed or the director issues a notice of intent to review the proposed and final order.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.704, ORS ch. 183
Hist: Amended 3/11/19 as WCD Admin. Order 19-050, eff. 4/1/19

Rulemaking

436-001-0005 Model Rules for Rulemaking

The Model Rules for Rulemaking, OAR 137-001-0005 through 137-001-0100, in effect on Jan. 1, 2008, adopted by the Oregon Department of Justice under ORS 183.341, are adopted as the rules of procedure for rulemaking actions of the Workers’ Compensation Division.

{ED. NOTE: The full text of the Model Rules is available from the Department of Justice, the division, or on the Oregon State Archives website at <https://secure.sos.state.or.us/oard/displayDivisionRules.action?electedDivision=281>. }

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 183.325 through 183.410
Hist: Amended 3/11/19 as WCD Admin. Order 19-050, eff. 4/1/19
Statutory minor correction (to Model Rules URL) – ORS 183.335(7), (WCD 2-2023) filed and effective 9/18/23

436-001-0009 Notice of Division Rulemaking

(1) Except when adopting a temporary rule, the division will give prior public notice of the proposed adoption, amendment, or repeal of any rule by:

(a) Publishing notice of the proposed rulemaking action in the Secretary of State’s Oregon Bulletin at least 21 days before the effective date of the rule;

(b) Notifying interested people and organizations on the division’s notification lists of proposed rulemaking actions under ORS 183.335; and

(c) Providing notice to legislators as required by ORS 183.335(15).

(2) A person or organization may elect to receive email or hard-copy notification of proposed rulemaking actions of the division.

(a) A person or organization may elect to subscribe to the division’s email notification service at

<https://service.govdelivery.com/accounts/ORDCBS/subscriber/new>.

(b) A person or organization may elect to receive hard-copy notification by sending a request in writing, including the person or organization’s full name and mailing address, to the following address:

Rules Coordinator
Workers’ Compensation Division
P.O. Box 14480
Salem, OR 97309-0405

Statutory authority: ORS 656.726 (4)
Statutes implemented: ORS 183.335 and 84.022
Hist: Amended 3/11/19 as WCD Admin. Order 19-050, eff. 4/1/19

Hearings

436-001-0019 Requests for Hearing

(1) A request for hearing on a matter within the director’s jurisdiction must be filed with the division no later than the filing deadline. Filing deadlines will not be extended except as provided in section (7) of this rule.

(2) A request for hearing must be in writing. A party may use the division’s [Form 2839](#), "Workers’ Compensation Division Request for Hearing," available on the division’s website at <http://wcd.oregon.gov/forms/Pages/forms.aspx>. A request for hearing must include the following information, as applicable:

(a) The name, address, and phone number of the party making the request;

(b) Whether the party making the request is the worker, insurer, medical provider, employer, any other party, or an attorney on behalf of a party;

(c) The number of the administrative order being appealed;

(d) The worker’s name, address, and phone number;

(e) The name, address, and phone number of the worker’s attorney, if any;

(f) The date of injury;

(g) The insurer’s or self-insured employer’s claim number;

(h) The division’s file number; and

(i) The reason for requesting a hearing.

(3) Requests for hearing may be filed in any of the following ways:

(a) By mail, to the following address:

WCD Hearings
Workers’ Compensation Division
P.O. Box 14480
Salem, OR 97309-0405

(b) By hand-delivery, to the following address:

WCD Hearings
350 Winter Street NE, 2nd floor
Salem, OR 97301

(c) By fax, to 503-947-7511, if the document transmitted indicates that it has been delivered by fax, is sent to the correct fax number, and indicates the date the document was sent.

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(d) By email, to wcd.hearings@dcbs.oregon.gov. If the request for hearing is an attachment to the email, it must be in a format that Microsoft Word 2010® (.docx, .doc, .txt, .rtf) or Adobe Reader® (.pdf) can open. Image formats that can be viewed in Internet Explorer® (.tif, .jpg) are also acceptable.

(e) By using the online form, available on the division's website at <https://wcd.oregon.gov/forms/pages/request-for-hearing.aspx>.

(4) The requesting party must send a copy of the request to all known parties and their legal representatives, if any.

(5) Timeliness of requests for hearing will be determined under OAR 436-001-0027.

(6) The director will refer timely requests for hearing to the board for a hearing before an administrative law judge. The director may withdraw a matter that has been referred if the matter is not appropriate for hearing at that time.

(7) The director will deny requests for hearing that are filed after the filing deadline. The requesting party may request a limited hearing on the denial of the request for hearing within 30 days after the mailing date of the denial. The request must be filed with the division. At the limited hearing, the administrative law judge may consider only whether:

- (a) The denied request for hearing was filed timely; or
- (b) Good cause existed that prevented the party from timely requesting a hearing on the merits. For the purpose of this rule, "good cause" includes, but is not limited to, mistake, inadvertence, surprise, or excusable neglect.

Statutory authority: ORS 656.726(4) and ORS 84.013

Statutes implemented: ORS 656.704

Hist: Amended 3/14/18 as WCD Admin. Order 18-052, eff. 4/1/18

Statutory minor correction (to DCBS email address) – ORS 183.335(7), (WCD 12-2021) filed and effective 10/27/21

Statutory minor correction (to hearing request URL) – ORS 183.335(7), (WCD 5-2022) filed and effective 6/14/22

436-001-0023 Other Filings and Submissions

(1) Except as provided in section (3) of this rule, any filing, motion, request, document, or correspondence filed or submitted in a matter within the director's jurisdiction must be filed or submitted:

- (a) To the division before the dispute is referred to the board;
- (b) To the administrative law judge after the dispute is referred to the board but before the administrative law judge issues a proposed and final order; and
- (c) To the division after the administrative law judge issues a proposed and final order, unless it is a request for correction of errors in the proposed and final order under OAR 436-001-0246(7).

(2) A copy of any filing, motion, request, document, or correspondence must be sent to the other parties, or their legal representatives, at the same time it is filed or submitted to the division or administrative law judge.

(3) A party must notify the division and the other parties of any changes in the party's mailing address or legal representation.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.704

Hist: Amended 11/16/12 as WCD Admin. Order 12-060, eff. 12/28/12

436-001-0027 Timeliness; Calculation of Time

(1) Timeliness of any document required by these rules to be filed or submitted to the division is determined as follows:

- (a) If a document is mailed, it will be considered filed on the date it is postmarked.
- (b) If a document is faxed or emailed, it must be received by the division by 11:59 p.m. Pacific Time to be considered filed on that date.
- (c) If a document is delivered, it must be delivered during regular business hours to be considered filed on that date.

(2) The date and time of receipt for electronic filings is determined under ORS 84.043.

(3) Time periods allowed for a filing or submission to the division are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.704

Hist: Amended 3/11/19 as WCD Admin. Order 19-050, eff. 4/1/19

436-001-0030 Role of the Workers' Compensation Division

(1) In any hearing, the director may request to:

- (a) Receive notice of all matters;
- (b) Receive copies of all documents; and
- (c) Present evidence, testimony, and argument.

(2) The director may appear in a matter by filing an entry of appearance. The director may be represented by an agency representative, assistant attorney general, or special assistant attorney general as authorized by the Department of Justice. If the director enters an appearance, all notices and documents in the hearing must be provided to the director's representative.

(a) An agency representative may represent the director in hearings held before the administrative law judges of the board to determine the correctness of:

- (A) An order under ORS 656.052 declaring a person to be a noncomplying employer ("NCE Orders");
- (B) A nonsubjectivity determination under ORS 656.052 declaring either that a person is not a subject employer or is not a subject worker ("NSD Orders");
- (C) An order assessing a civil penalty under ORS 656.735, 656.740, or 656.745(2);
- (D) An order under ORS 656.745(1) assessing a civil penalty against an employer or insurer with prior written consent of the Attorney-in-Charge of the Business Activities Section of the Department of Justice; and
- (E) An order under ORS 656.254(2) imposing sanctions to enforce medical reporting requirements.

(b) In cases assigned to lay representatives in accordance with subsection (a), above:

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(A) Lay representatives are authorized to handle all settlement negotiations related to proposed NCE Orders, NSD Orders, and civil penalty or forfeiture orders. All settlement documents will be reviewed for legal sufficiency by the Department of Justice unless they conform to a form settlement document approved by the Attorney-in-Charge of the Business Activities Section. All settlement documents submitted to the Department of Justice will be accompanied by the original proposed order and any subsequent orders issued by the division.

(B) If the division issues a worker nonsubjectivity denial instead of referring the claim to the assigned claims agent, the division's lay representative(s) may handle settlement negotiations resulting from that worker nonsubjectivity denial. Once a request for hearing has been filed contesting that worker nonsubjectivity denial, the lay representative(s) have seven calendar days within which to finalize any pending settlement negotiations and must coordinate settlement discussions with the assigned assistant attorney general or special assistant attorney general, who will assume representation on the case. The assistant attorney general or special assistant attorney general assigned to the case may extend the seven-day time period by authorizing the lay representative(s) to continue settlement negotiations. All settlement documents will be reviewed for legal sufficiency by the attorney assigned to the case before submission to an administrative law judge.

(c) Notwithstanding subsections (a) or (b) above, and under ORS 656.704, the Department of Justice will represent the division in all matters pertaining to a claim.

(3) The administrative law judge must not allow an agency representative appearing under section (2) of this rule to present legal argument as defined by this rule.

(a) "Legal argument" includes arguments on:

(A) The jurisdiction of the agency to hear the contested case;

(B) The constitutionality of a statute or rule or the application of a constitutional requirement to an agency; and

(C) The application of court precedent to the facts of the particular contested case proceeding.

(b) "Legal argument" does not include presentation of motions, evidence, examination and cross-examination of witnesses, or presentation of factual arguments or arguments on:

(A) The application of the statutes or rules to the facts in the contested case;

(B) Comparison of prior actions of the agency in handling similar situations;

(C) The literal meaning of the statutes or rules directly applicable to the issues in the contested case;

(D) The admissibility of evidence; and

(E) The correctness of procedures being followed in the contested case hearing.

(4) If the administrative law judge determines that statements or objections made by an agency representative appearing under section (2) involve legal argument as defined in this rule, the administrative law judge must provide reasonable opportunity

for the agency representative to consult the Attorney General and permit the Attorney General to present argument at the hearing or to file written legal argument within a reasonable time after conclusion of the hearing.

(5) An agency representative appearing under section (2) must read and be familiar with the Code of Conduct for Non-Attorney Representatives at Administrative Hearings dated June 1, 2011, as amended Oct. 1, 2011, which is maintained by the Oregon Department of Justice and available on its website at https://www.doj.state.or.us/wp-content/uploads/2017/06/code_of_conduct_oah_contested.pdf.

Statutory authority: ORS 183.452, 656.704, 656.726(4)

Statutes implemented: ORS 180.220(2), 180.235, 183.452, and 656.704

Hist: Amended 3/14/18 as WCD Admin. Order 18-052, eff. 4/1/18

SMC (repeal of ORS 656.750)– ORS 183.335(7), filed and effective 6/18/24

436-001-0170 Duties and Powers of the Administrative Law Judge

(1) The administrative law judge may conduct the hearing in any manner consistent with these rules that will achieve substantial justice.

(2) Unless provided otherwise by statute or rule and except as stated in section (3) of this rule, any order issued by an administrative law judge regarding a matter within the director's jurisdiction is a proposed and final order subject to review by the director under OAR 436-001-0246.

(3) When appropriate, the administrative law judge may issue an interim order. An interim order is not subject to review by the director under OAR 436-001-0246.

(4) The administrative law judge may dismiss requests for hearing as provided in OAR 436-001-0296.

(5) When appropriate, the administrative law judge may remand a dispute to the director for further administrative action.

(6) The administrative law judge may consolidate matters in which there are common parties or common issues of law or fact.

(7) The administrative law judge may separate matters to promote efficient disposition of the matters.

(8) Consolidation of matters under section (6) of this rule or under ORS 656.704(3)(c) is only for the purpose of hearing. The administrative law judge must issue a separate order for matters other than those concerning a claim.

(9) On the motion of a party, the division, or the administrative law judge, the administrative law judge may continue a hearing to allow the presentation of oral or written legal argument by the Department of Justice.

(10) The administrative law judge may send the division a written question regarding which rules or statutes apply to a matter, or regarding the division's interpretation of the rules and statutes. If the administrative law judge sends such a question, the administrative law judge must provide a written summary of the context in which the question arises, provide a reasonable time for the division to respond, and send a copy to all parties.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.704

Hist: Amended 3/14/18 as WCD Admin. Order 18-052, eff. 4/1/18

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436-001-0225 Scope of Review/Limitations on the Record

(1) Except for the matters listed in sections (2) and (3) of this rule and unless otherwise provided by statute or administrative rule:

(a) The administrative law judge reviews all matters within the director's jurisdiction de novo; and

(b) New evidence may be admitted and considered.

(2) In medical service and medical treatment disputes under ORS 656.245, 656.247(3)(a), and 656.327, and managed care disputes under ORS 656.260(16), the administrative law judge may modify the director's order only if it is not supported by substantial evidence in the record or if it reflects an error of law. New evidence or issues may not be admitted or considered.

(3) In vocational assistance disputes under ORS 656.340, new evidence may be admitted and considered. Under ORS 656.340(16), the administrative law judge may modify the director's order only if it:

(a) Violates a statute or rule;

(b) Exceeds the director's statutory authority;

(c) Was made upon unlawful procedure; or

(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.245, 656.247, 656.260, 656.327, 656.340, 656.704

Hist: Amended 3/14/18 as WCD Admin. Order 18-052, eff. 4/1/18

436-001-0240 The Record

(1) Not more than 30 days after referring a request for hearing to the board, the division will provide the parties and the administrative law judge with copies of all documents in the director's record.

(2) Not less than 28 days before the hearing, or within seven days of receipt of the director's record, whichever is later, the insurer or self-insured employer must provide the other parties legible copies of all documents, from the director's record, that the insurer or self-insured employer will rely on at hearing. The documents must be numbered and indexed as provided in OAR 438-007-0018(1).

(3) Not less than 14 days before the hearing, or within seven days of receipt of the insurer's or self-insured employer's documents and index, whichever is later, the other parties must provide legible copies of any additional documents, from the director's record, that they will rely on at hearing. The documents must be numbered and indexed as provided in OAR 438-007-0018(2).

(4) The parties may include with their documents and indexes documents that are not included in the director's record only if new evidence is allowed under OAR 436-001-0225.

(5) Before or at the hearing, the parties must submit their documents and indexes to the administrative law judge as provided in OAR 438-007-0018 or as otherwise required by the administrative law judge.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.704

Hist: Amended 3/11/19 as WCD Admin. Order 19-050, eff. 4/1/19

436-001-0246 Proposed and Final Orders - Exceptions, Correction, Director Review

(1) Under ORS 656.704(2)(a), a party must seek director review of a proposed and final order before petitioning for judicial review under ORS 183.482.

(2) The parties or the division may initiate director review of a proposed and final order by filing exceptions as follows:

(a) Written exceptions, including any argument, must be filed with the division within 30 days of the mailing date of the proposed and final order.

(b) A written response to the exceptions must be filed within 20 days of the date the exceptions were filed.

(c) A written reply to the response, if any, must be filed within 10 days of the date the response was filed.

(d) Exceptions, responses, and replies may be filed in any of the following ways:

(A) By mail, to the following address:

WCD Hearings

Workers' Compensation Division

P.O. Box 14480

Salem, OR 97309-0405

(B) By hand-delivery, to the following address:

WCD Hearings

350 Winter Street NE, 2nd floor

Salem, OR 97301

(C) By fax, to 503-947-7511, if the document transmitted indicates that it has been delivered by fax, is sent to the correct fax number, and indicates the date the document was sent.

(D) By email, to wcd.hearings@dcbs.oregon.gov. If the exception, response, or reply is in an attachment to the email, the attachment must be in a format that Microsoft Word 2010® (.docx, .doc, .txt, .rtf) or Adobe Reader® (.pdf) can open. Image formats that can be viewed in Internet Explorer® (.tif, .jpg) are also acceptable.

(3) The director may extend the time period for a party to file a response, reply, or argument upon the party's written request that explains the need for the delay or on the director's own motion. The time period for filing exceptions may not be extended.

(4) If exceptions are timely filed, the director may issue a final order or an amended proposed and final order, request the administrative law judge to hold further hearing, or remand the matter for further administrative action.

(5) Within 30 days of the mailing date of the proposed and final order, the director may issue a notice of intent to review the proposed and final order, even if no exceptions are filed.

(6) All proposed and final orders must contain language notifying the parties of their right to file exceptions, how to file, and the time frames.

(7) The administrative law judge may withdraw a proposed and final order for correction of errors within 10 calendar days of the mailing date of the order. The time for filing exceptions

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begins on the date the corrected proposed and final order is mailed.

(8) If no exceptions are timely filed or if no notice of intent to review is issued, the proposed and final order will become final 30 days after the mailing date of the order.

(9) Any requests for review or requests for reconsideration of a proposed and final order filed with the board or administrative law judge within 30 days of the mailing date of the order will be forwarded to the director and treated as timely exceptions under this rule.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.704

Hist: Amended 3/14/18 as WCD Admin. Order 18-052, eff. 4/1/18

Statutory minor correction (to DCBS email address) – ORS 183.335(7), (WCD 13-2021) filed and effective 10/27/21

436-001-0252 Stay of Director and Administrative Review

The director may stay director review, administrative review, or referral of a matter if there is another pending matter concerning a claim that may affect the outcome of the matter within the director's jurisdiction.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.704

Hist: Amended 3/14/18 as WCD Admin. Order 18-052, eff. 4/1/18

436-001-0259 Ex Parte Communication

An ex parte communication is an oral or written communication to the director during director review of the matter not made in the presence of all parties to the dispute, concerning a fact in issue, but does not include communication from division staff or the Department of Justice about legal issues or facts in the record. Ex parte communications received during director review will be promptly disclosed to all parties, and the parties will be allowed a reasonable opportunity to respond.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.704, OL 2005 ch 26

Hist: Amended 12/10/15 as WCD Admin. Order 15-065, eff. 1/1/16

436-001-0296 Settlements and Dismissals

(1) If, after a request for hearing is filed but before a proposed and final order is issued, an agreement under ORS 656.236 or 656.289(4) is approved that resolves all issues in the matter within the director's jurisdiction, the administrative law judge may issue a proposed and final order dismissing the request for hearing.

(2) If, after a request for hearing is filed but before a proposed and final order is issued, the parties reach agreement on all issues in the matter within the director's jurisdiction, the administrative law judge may issue a proposed and final order approving the agreement and dismissing the request for hearing.

(3) If the matter within the director's jurisdiction is consolidated with matters concerning a claim and the parties reach agreement on all issues in the matter within the director's jurisdiction before issuance of a proposed and final order, the administrative law judge may issue a proposed and final order approving the agreement and dismissing the request for hearing.

(4) Notwithstanding OAR 436-001-0170(2), the administrative law judge may issue a final order of dismissal when the

requesting party withdraws the request for hearing and no cross-request for hearing has been filed.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.704

Hist: Amended 3/14/18 as WCD Admin. Order 18-052, eff. 4/1/18

Attorney Fees

436-001-0400 General Provisions and Requirements for Attorney Fees

In addition to the specific provisions in OAR 436-001-0410 through 436-001-0440, the following provisions apply to attorney fees:

(1) The attorney must file with the director a signed attorney retainer agreement.

(2) In cases in which time devoted is required to be considered in determining the amount of the fee:

(a) The attorney should submit a statement of the number of hours spent on the case.

(b) The director may request the attorney to submit additional information to support or clarify the statement of hours.

(c) If the attorney does not submit a statement of hours or other information requested by the director before an order is issued, the director will presume the attorney spent one to two hours on the case.

(3) In cases in which a reasonable fee is to be determined, the director may consider the following factors:

(a) The time devoted to the case for legal services.

(b) The complexity of the issue(s) involved.

(c) The value of the interest involved.

(d) The skill of the attorneys.

(e) The nature of the proceedings.

(f) The benefit secured for the represented party.

(g) The risk in a particular case that an attorney's efforts may go uncompensated and the contingent nature of the practice.

(h) The assertion of frivolous issues or defenses.

Statutory authority: ORS 656.385(1), 656.726(4)

Statutes implemented: ORS 656.262, 656.277, 656.383, and 656.385

Hist: Amended 7/5/22 as WCD Admin. Order 22-061, eff. 9/1/22

436-001-0410 Attorney Fees Under ORS 656.385(1) (Medical and Vocational Disputes)

(1) In cases in which the director or administrative law judge orders a fee to be paid under ORS 656.385(1):

(a) The fee must fall within the ranges of the matrix in subsection (d), unless extraordinary circumstances are shown or the parties otherwise agree.

(b) Extraordinary circumstances are not established merely by exceeding eight hours or a benefit of \$6,000.

(c) The matrix in subsection (d) shows the maximum fee and fee ranges as percentages of the maximum fee under ORS 656.385(1), as adjusted annually by the same percentage increase, if any, to the average weekly wage defined in ORS 656.211. Before July 1 of each year the director will publish in [Bulletin 356](#) (available on the division's website at

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http://wcd.oregon.gov/Bulletins/bul_356.pdf) the matrix showing the maximum fee and fee ranges as dollar amounts after the annual adjustment to the statutory maximum fee. Dollar amounts will be rounded to the nearest whole dollar. If the average weekly wage does not change or decreases, the

maximum attorney fee under ORS 656.385(1) will not be adjusted for that year.

(d)

Estimated Benefit Achieved	Professional Hours Devoted (Fees as percentage of adjusted maximum attorney fee under ORS 656.385(1))		
	1-4 hours	4.1-8 hours	over 8 hours
\$1-\$2,000	5.0% - 35.0%	15.0% - 50.0%	40.0% - 62.5%
\$2,001-\$4,000	10.0% - 40.0%	30.0% - 65.0%	52.5% - 75.0%
\$4,001-\$6,000	15.0% - 50.0%	40.0% - 72.5%	65.0% - 87.5%
Over \$6000	20.0% - 65.0%	52.5% - 90.0%	77.5% - 100.0%

(2) For purposes of applying the matrix in medical disputes under ORS 656.245, 656.247, 656.260, and 656.327, the following may be considered in determining the value of the results achieved or the benefit to the worker:

(a) The fee allowed by the medical fee schedule in OAR 436-009 for the medical service at issue.

(b) The overall cost of the medical service at issue.

(3) For purposes of applying the matrix in vocational disputes under ORS 656.340, the value of vocational assistance or a training plan, unless determined to be otherwise, falls within the highest range of the matrix for *benefit achieved*. In addition, the following may be considered in determining the value of the results achieved or the benefit to the worker:

(a) The actual or projected cost of the service at issue.

(b) The maximum spending limit in the fee schedule for vocational assistance costs in OAR 436-120-0720 (as published in [Bulletin 124](#), available on the division's website at http://wcd.oregon.gov/Bulletins/bul_124.pdf) for the service at issue.

Statutory authority: ORS 656.385(1), 656.726(4)

Statutes implemented: ORS 656.385

Hist: Amended 7/5/22 as WCD Admin. Order 22-061, eff. 9/1/22

**436-001-0420 Attorney Fees Under ORS 656.262(11)
(Late Payment of Compensation)**

In cases in which the director orders a fee to be paid under ORS 656.262(11):

(1) OAR 438-015-0110 applies.

(2) The director may use the matrix in OAR 436-001-0410 as a guide in determining the amount of the fee.

(3) The director must consider the proportionate benefit to the worker when determining the amount of the fee.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.262

Hist: Amended 7/5/22 as WCD Admin. Order 22-061, eff. 9/1/22

**436-001-0430 Attorney Fees Under ORS 656.262(12)
(Late Payment of DCS Proceeds)**

The matrix for determining the amount of the attorney fee under ORS 656.262(12) is in OAR 436-060, Appendix C (OAR 436-060-0400).

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.262

Hist: Amended 7/5/22 as WCD Admin. Order 22-061, eff. 9/1/22

**436-001-0432 Attorney Fees Under ORS 656.268(6)(c)
(Additional Compensation at Reconsideration) [new rule]**

For attorney fees under ORS 656.268(6)(c):

(1) In addition to a signed retainer agreement required under OAR 436-001-0400(1), the attorney must submit the request for reconsideration on behalf of the worker.

(2) The insurer must pay the attorney 10 percent out of any additional compensation awarded. "Additional compensation" includes an increase in a permanent or temporary disability award.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.268(6)(c)

Hist: Adopted 7/5/22 as WCD Admin. Order 22-061, eff. 9/1/22

**436-001-0435 Attorney Fees Under ORS 656.277(1)
(Reclassification)**

(1) Attorney fees under ORS 656.277(1) will be based on a reasonable hourly rate multiplied by the time devoted by the attorney to obtaining the reclassification order.

(2) The director will determine a reasonable hourly rate of no less than \$292 per hour and no more than \$425 per hour. These amounts will be adjusted annually by the same percentage increase, if any, to the average weekly wage defined in ORS 656.211. Adjusted amounts will be published before July 1 of each year in Bulletin 356 (available on the division's website at http://wcd.oregon.gov/Bulletins/bul_356.pdf). Dollar amounts will be rounded to the nearest whole dollar. If the average weekly wage does not change or decreases, amounts will not be adjusted for that year.

(3) When determining the time devoted by the attorney to obtain the reclassification order, the director may consider time

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devoted by the attorney to request reclassification from the insurer or self-insured employer and investigate issues related to the classification of the worker's claim.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.277(1)

Hist: Amended 7/5/22 as WCD Admin. Order 22-061, eff. 9/1/22

**436-001-0438 Attorney Fees Under ORS 656.383(1)
(Temporary Disability Compensation Benefits) [new rule]**

(1) An attorney fee under ORS 656.383(1) is payable after an order on reconsideration under ORS 656.268 is issued, as provided in this rule. If attorney fees under ORS 656.383(1) are at issue at hearing or on board review, the rules in OAR chapter 438 apply.

(2) Using the matrix in section (5) of this rule, the insurer must calculate the amount of and pay to the worker's attorney a fee when:

(a) The worker disagrees with the temporary disability dates shown on the Notice of Closure and raises it as an issue in the request for reconsideration under ORS 656.268;

(b) The reconsideration order issued under ORS 656.268 modifies the temporary disability dates shown on the Notice of Closure;

(c) As a result of the modification of the temporary disability dates, the insurer determines additional temporary disability compensation benefits are due and payable to the worker; and

(d) The worker was represented by an attorney in the reconsideration proceeding.

(3)(a) The total fee under this rule, not including any fee under ORS 656.268(6)(c), may not exceed \$5,600. The maximum amount will be adjusted annually by the same percentage increase, if any, to the average weekly wage defined in ORS 656.211. The adjusted amount will be published before July 1 of each year in Bulletin 356 (available on the division's website at http://wcd.oregon.gov/Bulletins/bul_356.pdf). If the average weekly wage does not change or decreases, the maximum will not be adjusted for that year.

(b) The formula in the matrix is intended to result in a reasonable fee that considers the time devoted by the attorney to the issue of temporary disability compensation, that is proportionate to the benefit to the worker, and that takes into account the out-of-compensation fee under ORS 656.268(6)(c).

(4) If the criteria in subsections (2)(a), (b), and (d) are met, the director will make a finding in the order on reconsideration issued under ORS 656.268 regarding the number of hours the attorney devoted to the issue of temporary disability compensation.

(a) A statement of services will be considered if submitted within 14 days of the date the reconsideration proceeding begins as provided in OAR 436-030-0145(2).

(b) If a statement of services is not submitted within 14 days of the date the reconsideration proceeding begins, the director will presume the attorney devoted one to two hours to the issue of temporary disability compensation.

(c) A statement of services submitted more than 14 days after the reconsideration proceeding begins will not be considered by the director, but will be included in the record.

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(5) The amount of the attorney fee under this rule is to be calculated by adding (a) a base amount for the time devoted by the attorney to the issue of temporary disability compensation to (b) a percentage of the additional amount of temporary disability compensation benefits due and payable to the worker. Dollar amounts should be rounded to the nearest whole dollar.

(a) Base amount for time devoted by the attorney	
Up to 2 hours	\$500
2.1-4 hours	\$1,000
4.1-6 hours	\$1,500
More than 6 hours	\$2,000
PLUS	
(b) Percentage of additional amount of temporary disability compensation benefits due and payable to the worker	
If the additional amount of temporary disability compensation benefits due and payable is:	Add the following percentage of the additional amount of temporary disability compensation benefits due and payable:
Up to \$500	10%
\$501-\$1,000	15%
\$1,001-\$2,500	20%
\$2,501-\$5,000	25%
\$5,001 or more	30%
The maximum fee is \$5,600, subject to annual adjustment as provided in subsection (3)(a) of this rule.	

Example: If the attorney spent 4-1/2 hours on the issue of temporary disability compensation and the amount of additional temporary disability compensation benefits due and payable to the worker is \$2,174, the attorney fee is the base amount of \$1,500 plus \$435 ($\$2,174 \times 0.20 = \434.80 , round up to \$435), for a total fee of \$1,935.

(6) If a party disputes the entitlement to or the amount of an attorney fee under this rule, that party may request a hearing before the Workers' Compensation Board. The Administrative Law Judge and board are not bound by this rule in determining whether a fee under ORS 656.383(1) is due or in determining the amount of the fee.

(7) Disputes regarding attorney fees under ORS 656.383(1) in reconsideration proceedings under ORS 656.268 are not matters under ORS 656.704(2)(a).

(8) An attorney fee under ORS 656.383(1) and this rule must be paid in addition to an attorney fee under ORS 656.268(6)(c) and OAR 436-001-0432.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.383(1)
Hist: Adopted 7/5/22 as WCD Admin. Order 22-061, eff. 9/1/22

436-001-0440 Time Within Which Attorney Fees Must be Paid

Attorney fees under OAR 436-001-0400 to 436-001-0438 must be paid within 14 days of the date the order addressing the fees becomes final.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.262, 656.268, 656.277, 656.383, 656.385
Hist: Amended 7/5/22 as WCD Admin. Order 22-061, eff. 9/1/22

General Provisions

436-001-0500 Refund of Overpayments

When the director receives a payment in excess of the amount legally due and payable to the director, the director will refund or credit the excess amount. However, when the excess amount is less than \$20 and the payment was for an assessment or civil penalty issued under OAR chapter 436 or ORS chapter 656, the director will refund or credit the excess amount only if a written request for refund or credit is received within two years of the date that the excess amount was received by the director.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.506, 656.612, 656.614, 656.735, 656.745, 656.780, and 293.445
Hist: Adopted 12/10/15 as WCD Admin. Order 15-065, eff. 1/1/16
SMC (repeal of ORS 656.750)— ORS 183.335(7), filed and effective 6/18/24

436-001-0600 Multilingual Help Page

(1) An insurer, self-insured employer, service company, or managed care organization (MCO) that sends a document to a worker that is required by OAR chapter 436 must simultaneously send [Form 5377](#), "Workers' Compensation Multilingual Help Page," if the document includes:

(a) Appeal rights;

(b) A deadline for action required to obtain or preserve a right or benefit, including dates of required medical examinations or vocational evaluations; or

(c) Notice of action required to prevent or reverse a suspension or reduction of benefits.

(2) [Form 5377](#) is published under [Bulletin 379](#).

(3) [Bulletin 379](#) lists the notices described by subsections (1)(a) through (c).

(4) Failure to send [Form 5377](#) with a document as required by this rule does not affect the validity of the document, but may subject the insurer, self-insured employer, service company, or MCO to civil penalties under ORS 656.745.

(5) [Form 5377](#) must be sent as provided by section (1) of this rule for documents sent to a worker on or after June 1, 2019.

Statutory authority: ORS 656.726(4); 656.260
Statutes implemented: ORS 656.726(4); 656.260
Hist: Adopted 3/11/19 as WCD Admin. Order 19-050, eff. 4/1/19

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436-001-0610 Duty to Forward Misdirected Request

If an employer or insurer receives a written request for hearing or administrative review from a worker, and the request should have been filed with the division, the employer or insurer must promptly forward the request to the division.

Statutory authority: ORS 656.726(4); Statutes implemented: ORS 656.704
Hist: Adopted 3/11/19 as WCD Admin. Order 19-050, eff. 4/1/19

436-001-0700 Access to Public Records and Workers' Compensation Claim Records

(1) Access to public records. Department of Consumer and Business Services rules on Access of Public Records, Fees for Record Search and Copies of Public Records are in OAR 440-005, accessible at

<https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=2100>.

(2) Inspection of nonexempt public records. Any person has a right to inspect and obtain copies of nonexempt public records but not to request blind searches for records not known to exist.

(3) Access to workers' compensation claim records.

(a) The department's workers' compensation claim records are exempt from public disclosure under ORS 192.355.

(b) Access to claim records will be granted at the sole discretion of the director, under the following circumstances:

(A) When necessary for an insurer, self-insured employer, service company, or their attorney, for the purpose of processing a workers' compensation claim;

(B) When necessary for the director to carry out the director's duties, functions, or powers;

(C) When necessary for a governmental agency of Oregon or the United States to carry out its duties, functions, or powers;

(D) When a worker or the worker's representative requests the worker's claim record; or

(E) When disclosure can be made in a way that the disclosed information cannot be used to identify any worker who is the subject of an Oregon workers' compensation claim.

(4) Requests for claim records. A request to inspect or obtain copies of workers' compensation claim records may be made in writing, in person, or by phone. Requesters may use the division's [Form 3088](#), "Request for Workers' Compensation Claim Records."

(a) Written requests must include:

(A) The name, identity, and contact information of the requester;

(B) Information identifying the worker or the claim;

(C) A description of the records requested; and

(D) The signature of the requester certifying the requester meets the criteria in subsection (3)(b) of this rule.

(b) In addition to the information required under subsection (a) of this section, requests for claims history made by phone or fax must include, if known:

(A) The worker's Social Security number; and

(B) The insurer claim number.

(c) A request from the worker's representative must be accompanied by an attorney retainer agreement or a valid release signed by the worker.

(d) A request from a person other than as described in subsection (3)(b) of this rule must include a valid release signed by the worker.

(e) The director may require additional information or documentation to ensure records are released in accordance with ORS 192.355 and this rule.

(5) Release of claim records to other persons. The director may release workers' compensation claim records to persons other than those described in (3)(b) of this rule including public or private research organizations.

(a) The determination whether to release the information is at the sole discretion of the director.

(b) The director may enter into written agreements as necessary to ensure that the recipient of the information uses the information only in accordance with this rule and the agreement with the director to ensure confidentiality of the disclosed records. The director may terminate such agreements at any time the director determines that one or more of the conditions of the agreement have been violated.

(c) The director may deny or revoke access to workers' compensation claims records at any time.

Statutory authority: ORS 192.318, 192.355, and 656.726(4)
Statutes implemented: ORS 656.726(4), 192.318, and 192.355
Hist: Adopted 3/13/20 as WCD Admin. Order 20-052, eff. 4/1/20

**CHAPTER 436, DIVISION 008
OREGON ADMINISTRATIVE RULES**

ELECTRONIC MEDICAL BILLING

Effective Jan. 1, 2015

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436-008-0001 Authority, Applicability, Purpose, and Administration of these Rules

(1) These rules are promulgated under the director's authority contained in ORS 656.726(4) and specific authority under ORS 656.252.

(2) These rules apply to all electronic medical billing transactions generated on or after the effective date of these rules.

(3) The purpose of these rules is to establish uniform guidelines for the exchange of electronic medical billing transactions within the workers' compensation system.

(4) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(5) Orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 are considered orders of the director.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254, 656.726(4)
Hist: Adopted 7/14/14 as Admin. Order 14-058, eff. 1/1/15

436-008-0004 Adoption of Standards

(1) The director adopts, by reference, the following electronic medical bill processing standards:

(a) Professional Billing:

(A) The Accredited Standards Committee X12 (ASC X12) Standards for Electronic Data Interchange (EDI) Type 3 Technical Reports (TR3);

(B) Health Care Claim: Professional (837), May 2006, ASC X12, 005010X222; and

(C) Type 3 Errata to Health Care Claim: Professional (837), June 2010, ASC X12, 005010X222A1.

(b) Institutional/Hospital Billing:

(A) The ASC X12 Standards for EDI TR3;

(B) Health Care Claim: Institutional (837), May 2006, ASC X12, 005010X223;

(C) Type 1 Errata to Health Care Claim: Institutional (837);

(D) ASC X12 Standards for EDI TR3, October 2007, ASC X12, 005010X223A1; and

(E) Type 3 Errata to Health Care Claim: Institutional (837), June 2010, ASC X12, 005010X223A2.

(c) Dental Billing:

(A) The ASC X12 Standards for EDI TR3;

(B) Health Care Claim: Dental (837), May 2006, ASC X12, 005010X224;

(C) Type 1 Errata to Health Care Claim: Dental (837);

(D) ASC X12 Standards for EDI Technical Report Type 3, October 2007, ASC X12, 005010X224A1; and

(E) Type 3 Errata to Health Care Claim: Dental (837), June 2010, ASC X12, 005010X224A2.

(d) Retail Pharmacy Billing:

(A) The Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, National Council for Prescription Drug Programs (NCPDP); and

(B) The Batch Standard Batch Implementation Guide, Version 1, Release 2 (Version 1.2), January 2006, NCPDP.

(e) Remittance:

(A) The ASC X12 Standards for EDI TR3, Health Care Claim Payment/Advice (835), April 2006, ASC X12, 005010X221; and

(B) Type 3 Errata to Health Care Claim Payment/Advice (835), June 2010, ASC X12, 005010X221A1.

(2) The director adopts, by reference, the following electronic standards for medical bill acknowledgments:

(a) The ASC X12 Standards for EDI TA1 Interchange Acknowledgment contained in the standards adopted under section (1) of this rule;

(b) The ASC X12 Standards for EDI TR3, Implementation Acknowledgment for Health Care Insurance (999), June 2010, ASC X12, 005010X231A1;

(c) The ASC X12 Standards for EDI TR3, Health Care Claim Acknowledgment (277CA), January 2007, ASC X12, 005010X214; and

(d) Electronic responses to NCPDP transactions, and the response contained in the standards adopted under subsection (1)(d).

(3) The director adopts, by reference, the ASC X12N 275 - Additional Information to Support a Health Claim or Encounter, Version 005010, February 2008, 005010X210, for attachments to medical bills.

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(4) The director adopts, by reference, the ASC X12N/2013-57, effective Dec. 2013, Code Value Usage in Health Care Claim Payments and Subsequent Claims Technical Report Type 2.

(5) ASC X12N and the ASC X12 standards for EDI may be purchased from the ASC X12, 7600 Leesburg Pike, Suite 430, Falls Church, VA 22043; telephone 703-970-4480; and fax 703-970-4488. They are also available for purchase through the internet at <http://www.X12.org>.

(6) Retail pharmacy standards may be purchased from the NCPDP, 9240 East Raintree Drive, Scottsdale, AZ 85260, telephone 480-477-1000; fax 480- 767-1042. They are also available, for purchase, through the Internet at <http://www.ncdpd.org>.

(7) The director adopts the Oregon Workers' Compensation Division Electronic Billing and Payment Companion Guide Release 1.0, Jan. 1, 2015. A copy of the guide is available at the following website:

<http://wcd.oregon.gov/insurer/edi/Pages/ebilling.aspx>.

(8) Copies of the standards referenced in this rule are available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301, 503-947-7717.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)

Stats. Implemented: ORS 656.252, 656.254

Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0005 Definitions

For the purpose of these rules and the Oregon Electronic Billing and Payment Companion Guide:

(1) "**Clearinghouse**" means an entity that is an authorized agent of the insurer or health care provider, including billing services, re-pricing companies, community health management information systems or community health information systems, and "value-added" networks and switches that does either of the following functions:

(a) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(b) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

(2) "**Companion guide**" means the Oregon Workers' Compensation Division Electronic Billing and Payment Companion Guide adopted by the division in these rules that provides standards for workers' compensation electronic billing transactions.

(3) "**Complete electronic bill submission**" means an electronic medical billing transaction that is populated with current and valid values defined in the applicable standard set forth in OAR 436-008-0004 that:

(a) Includes the correct billing format, with the correct billing code sets;

(b) Is transmitted in compliance with all necessary format requirements; and

(c) Contains, in legible text, all supporting documentation that is expressly required by law or can reasonably be expected by the payer or its agent under the jurisdiction's law.

(4) "**Days**" means calendar days. For calendar days, the first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

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

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

(7) "**Electronic**" refers to a communication between computerized data exchange systems that complies with the standards set forth in these rules.

(8) "**Explanation of benefits (EOB)**" means an electronic remittance advice (ERA) or notification, sent or made available electronically by the insurer or an authorized agent of the insurer, to the health care provider, health care facility, or third-party biller or assignee regarding payment or denial of a bill, reduction of a bill, or refund.

(9) "**Insurer**" means:

(a) The State Accident Insurance Fund Corporation;

(b) An insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon;

(c) An insurer-authorized agent or payer;

(d) An assigned claims agent selected by the director under ORS 656.054; or

(e) An employer or employer group that has been certified under ORS 656.430 meeting the qualifications of a self-insured employer under ORS 656.407.

(10) "**Medical Bill**" means a statement of charges for medical services.

(11) "**Payer**" means the insurer or an entity authorized to make payments on behalf of the insurer.

(12) "**Supporting documentation**" means those documents necessary for the insurer to process a bill, including but not limited to medical reports and records, evaluation reports, narrative reports, assessment reports, progress report/notes, chart notes, hospital records, and diagnostic test results.

(13) "**Trading partner**" means any entity that exchanges information electronically with another entity.

Stat. Auth.: ORS 656.252, 656.726(4)

Stats. Implemented: ORS 656.726(4)

Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0010 Electronic Medical Bills

(1) Beginning Jan. 1, 2015, insurers must accept and process all electronically transmitted medical bills in accordance with these rules, the standards adopted under OAR 436-008-0004, and the companion guide.

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14-058**

(2) An insurer is exempt from the requirement to accept medical bills electronically from health care providers on or after Jan. 1, 2015, if a written notice is sent to the division, and approved by the director, on or before close of business on Dec. 31, 2014. The notice must explain in detail that the cost of electronic medical bill implementation will create an unreasonable financial hardship.

(3) Health care providers that elect to submit electronic medical bills to insurers must do so in accordance with these rules, the standards adopted under OAR 436-008-0004, and companion guide.

(4) All electronic medical billing transactions must be populated with current and valid values defined in the applicable standard set forth in OAR 436-008-0004.

(5) The health care provider, health care facility, third-party biller or assignee and the insurer may mutually agree to use nonstandard formats, but those formats must include all data elements required under the applicable standard, as set forth in OAR 436-008-0004.

(6) Health care providers and insurers may contract with other entities for electronic medical bill processing.

(7) Insurers and health care providers are responsible for the acts or omissions of their agents executed in the performance of electronic medical billing services.

(8) The data elements transmitted as part of a Trading Partner Agreement must at a minimum contain all the same required data elements found within the ASC X12 Type 3 Technical Reports and the jurisdiction-specific companion guide.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0015 Electronic Medical Bill Attachments or Documentation

(1) A unique attachment indicator number must be assigned to all documentation. The attachment indicator number populated on the document must include the report type code, the report transmission code, the attachment control qualifier, and the attachment control number.

(2) Documentation in support of electronic medical bills may be submitted by fax, secure email, regular mail, electronic transmission using the prescribed format, or by a mutually agreed upon format.

(3) Documentation in support of electronic medical bills must be submitted within five days of submission of the bill and include the following elements:

- (a) Patient name (ill or injured worker);
- (b) Date of birth (if available);
- (c) Employer name;
- (d) Insurer name;
- (e) Date of service;
- (f) Claim number (if no claim number then use "UNKNOWN"); and
- (g) Unique attachment indicator number.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0020 Electronic Medical Bill Acknowledgements

(1) If the electronic submission does not conform to the standards adopted under OAR 436-008-0004(1), then the insurer must send an acknowledgment adopted under OAR 436-008-0004(2)(a) or OAR 436-008-0004(2)(b) to the health care provider. This acknowledgement must be sent within one day of receipt of the electronic bill unless the electronic submission lacks sufficient identifiers to create an acknowledgment.

(2) If the electronic submission does conform to a standard adopted under OAR 436-008-0004(1), then the insurer must send an acknowledgment adopted under OAR 436-008-0004(2)(c) to the health care provider within two days.

(3) Any acknowledgment of a medical bill, as provided in (1) or (2) of this rule is not an admission of liability by the insurer.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0025 Electronic Medical Bill Payments

(1) Insurers that accept and process a complete electronic bill for services, under OAR 436-008-0010(1) (a) or (b), must pay for treatment related to the injury or disease, provided or authorized by the treating health care provider, on accepted claims within 14 days of any action causing the service to be payable, or within 45 days of receipt of the electronic bill, whichever is later.

(2) If an insurer requires additional information before a payment decision can be made, a request for this information must be made to the medical provider within 20 days of receipt of the bill.

(3) The insurer must provide an explanation (EOB) of services being paid or denied.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.252, 656.254
Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0030 Electronic Remittance Advice; Explanation of Benefits

(1) An electronic remittance advice (ERA) or notification is an explanation of benefits (EOB) that the insurer submits electronically regarding payment or denial of a bill, reduction of a bill, or refund. An insurer must submit an EOB no later than five days after generating a payment.

(2) The EOB must include:

(a) The amount of payment for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;

(b) The specific reason for non-payment, reduced payment, or discounted payment for each service billed; and

(c) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a health care provider's payment question within 48 hours, excluding weekends and legal holidays.

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(3) The insurer must make available, to health care providers, the applicable information specified under OAR 436-009-0030(3)(c)(A) through (F), including:

"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the director of the Department of Consumer and Business Services. Your request for review must be made within 90 calendar days of the send/receive date of this explanation. To request a review, provide information that shows what you believe is incorrect about the payment, and send this information and required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, P.O. Box 14480, Salem, OR 97309-0405. You may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this information for your records."

(4) Any information required under sections (1) through (3) of this rule that cannot be submitted on the electronic EOB must be made available on the insurer's website or by any other means reasonably convenient for the EOB recipient.

Stat. Auth.: ORS 656.252, 656.254, 656.726(4)

Stats. Implemented: ORS 656.252, 656.254

Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

436-008-0040 Assessment of Civil Penalties

Under ORS 656.745, the director may assess a civil penalty against an insurer that fails to comply with ORS chapter 656, the director's rules, or orders of the director.

Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 656.254, 656.745

Hist: Adopted 7/14/14 as Admin. Order14-058, eff. 1/1/15

[Electronic Billing and Payment Companion Guide](#) {LINK}

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009
OREGON MEDICAL FEE AND PAYMENT

Effective April 1, 2025

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***NOTE:** The text in rules 0023, 0040, 0060, and 0080 may not be revised, but new billing codes are included in the related fee schedules (Appendices B, C, D, E) effective Jan. 1, 2025.

436-009-0001 Purpose and Applicability of These Rules

(1) Purpose. The purpose of these rules is to establish uniform standards for administering the payment for medical benefits to workers within the workers' compensation system.

(2) Applicability of Rules.

(a) These rules apply to all services rendered on or after the effective date of these rules.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(c) Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.248

Hist: Amended 3/3/21 as Admin. Order 21-051, eff. 4/1/21

436-009-0004 Adoption of Standards

(1) The director adopts, by reference, the American Society of Anesthesiologists ASA, Relative Value Guide 2025 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide 2024, contact the American Society of Anesthesiologists, 1061 American Lane, Schaumburg, IL 60173, 847-825-5586, or www.asahq.org.

(2) The director adopts, by reference, the American Medical Association's (AMA) Current Procedural Terminology (CPT® 2025), Fourth Edition Revised, 2024, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT® 2025 govern the descriptions of services, except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.

(3) The director adopts, by reference, the AMA's CPT® Assistant, Volume 0, Issue 04 1990 through Volume 33, Issue 12, 2024. If there is a conflict between CPT® 2025 and the CPT® Assistant, CPT® 2025 is the controlling resource.

(4) To get a copy of the CPT® 2025 or the CPT® Assistant, contact the American Medical Association, AMA Plaza, 330 N. Wabash Ave., Suite 39300, Chicago, IL 60611-5885, 312-464-4782, or www.ama-assn.org.

(5) The director adopts, by reference, only the alphanumeric codes from the CMS Healthcare Common Procedure Coding System (HCPCS). These codes are to be used when billing for services, but only to identify products, supplies, and services that are not described by CPT® codes or that provide more detail than a CPT® code.

(a) Except as otherwise provided in these rules, the director does not adopt the HCPCS edits, processes, exclusions, color-coding and associated instructions, age and sex edits, notes, status indicators, or other policies of CMS.

(b) To get a copy of the HCPCS, contact the National Technical Information Service, Springfield, VA 22161, 800-621-8335 or

www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alphabetic-Numeric-HCPCS.html.

(6) The director adopts, by reference, CDT 2025: Dental Procedure Codes, to be used when billing for dental services. To get a copy, contact the American Dental Association at American Dental Association, 211 East Chicago Ave., Chicago, IL 60611-2678, 312-440-2500, or www.ada.org.

(7) The director adopts, by reference, the 02/12 1500 Claim Form and Version 12.0 7/24 (for the 02/12 form) 1500 Health Insurance Claim Form Reference Manual published by the National Uniform Claim Committee (NUCC). To get copies, contact the NUCC, American Medical Association, PO Box 74008935, Chicago, IL 60674-8935, or www.nucc.org.

(8) The director adopts, by reference, the Official UB-04 Data Specifications Manual 2024 Edition, published by National Uniform Billing Committee (NUBC). To get a copy, contact the NUBC, American Hospital Association, 155 North Wacker Drive, Suite 400, Chicago, IL 60606, 312-422-3000, or www.nubc.org.

(9) The director adopts, by reference, the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.4 (7/2015) and the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) Version 1.1 – 5/2009. To get a copy, contact the National Council for Prescription Drug Programs (NCPDP), 9240 East Raintree Drive, Scottsdale, AZ 85260-7518, 480-477-1000, or www.ncdp.org.

(10) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in ASA Relative Value Guide 2025, CPT® 2025, CPT® Assistant, HCPCS 2025, CDT 2025, 1500 Health Insurance Claim Form Reference Instruction Manual, Official UB-04 Data Specifications Manual, or NCPDP Manual Claim Forms Reference Implementation Guide.

(11) Copies of the standards referenced in this rule are also available for review during regular business hours at the Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, Salem, OR 97301.

Stat Auth: ORS 656.248, 656.726(4); Stats Implemented: ORS 656.248
Hist: Amended 3/5/24 as Admin. Order 24-050, eff. 4/1/24
Amended 12/9/25 as Admin. Order 24-055, eff. 1/1/25 Temp
Amended 3/11/25 as Admin. Order 24-050, eff. 4/1/25

436-009-0005 Definitions

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made part of these rules.

(2) Abbreviations used in these rules are either defined in the rules in which they are used or defined as follows:

(a) CMS means Centers for Medicare & Medicaid Services.

(b) CPT® means Current Procedural Terminology published by the American Medical Association.

(c) DMEPOS means durable medical equipment, prosthetics, orthotics, and supplies.

(d) EDI means electronic data interchange.

(e) HCPCS means Healthcare Common Procedure Coding System published by CMS.

(f) ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3 by US Department of Health and Human Services.

(g) ICD-10-CM means International Classification of Diseases, Tenth Revision, Clinical Modification.

(h) MCO means managed care organization certified by the director.

(i) NPI means national provider identifier.

(j) OSC means Oregon specific code.

(k) PCE means physical capacity evaluation.

(l) WCE means work capacity evaluation.

(3) “**Administrative review**” means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001.

(4) “**Ambulatory surgery center**” or “**ASC**” means:

(a) Any distinct entity licensed by the state of Oregon, and operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization; or

(b) Any entity outside of Oregon similarly licensed, or certified by Medicare or a nationally recognized agency as an ASC.

(5) “**Attending physician**” has the same meaning as described in ORS 656.005(12)(b). See Appendix A, “Matrix for Health Care Provider Types.”

(6) “**Authorized nurse practitioner**” means a nurse practitioner licensed under ORS 678.375 to 678.390 who has certified to the director that the nurse practitioner has reviewed informational materials about the workers' compensation system provided by the director and who has been assigned an authorized nurse practitioner number by the director.

(7) “**Board**” means the Workers' Compensation Board and includes its Hearings Division.

(8) “**Chart note**” means a notation made in chronological order in a medical record in which the medical service provider records such things as subjective and objective findings, diagnosis, treatment rendered, treatment objectives, and return to work goals and status.

(9) “**Clinic**” means a group practice in which several medical service providers work cooperatively.

(10) “**CMS form 2552**” (Hospital and Hospital Health Care Complex Cost Report) means the annual report a hospital makes to Medicare.

(11) “**Current procedural terminology**” or “**CPT®**” means the Current Procedural Terminology codes and terminology published by the American Medical Association unless otherwise specified in these rules.

(12) “**Date stamp**” means to stamp or display the initial receipt date and the recipient's name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.

(13) “**Days**” means calendar days.

(14) “**Director**” means the director of the Department of Consumer and Business Services or the director's designee.

(15) “**Division**” means the Workers' Compensation Division of the Department of Consumer and Business Services.

(16) “**Enrolled**” means an eligible worker has received notification from the insurer that the worker is being required to receive treatment under the provisions of a managed care organization (MCO). However, a worker may not be enrolled who would otherwise be subject to an MCO contract if the worker's primary residence is more than 100 miles outside the MCO's certified geographical service area.

(17) “**Fee discount agreement**” means a direct contract entered into between a medical service provider or clinic and an insurer to discount fees to the medical service provider or clinic under OAR 436-009-0018.

(18) “**Good Cause**” means circumstances that are outside the control of a party or circumstances that are considered to be extenuating by the division.

(19) **"Hospital"** means an institution licensed by the State of Oregon as a hospital.

(a) **"Inpatient"** means a patient who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

(b) **"Outpatient"** means a patient not admitted to a hospital prior to and extending past midnight for treatment and lodging. Medical services provided by a health care provider such as emergency room services, observation room, or short stay surgical treatments that do not result in admission are also considered outpatient services.

(20) **"Initial claim"** means the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared to be medically stationary by an attending physician or authorized nurse practitioner. For nondisabling claims, the "initial claim" means the first period of medical treatment immediately following the original filing of the occupational injury or disease claim ending when the attending physician or authorized nurse practitioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

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

(22) **"Interim medical benefits"** means those services provided under ORS 656.247 on initial claims with dates of injury on or after January 1, 2002, that are not denied within 14 days of the employer's notice of the claim.

(23) **"Interpreter"** means a person who:

(a) Provides oral or sign language translation; and

(b) Owns, operates, or works for a business that receives income for providing oral or sign language translation. It does not include a medical provider, medical provider's employee, or a family member or friend of the worker.

(24) **"Interpreter services"** means the act of orally translating between a medical provider and a worker who speak different languages, including sign language. It includes reasonable time spent waiting at the location for the medical provider to examine or treat the worker as well as reasonable time spent on necessary paperwork for the provider's office.

(25) **"Legal holidays"** means holidays listed in ORS 187.010 and 187.020.

(26) **"Mailed or mailing date"** means the date a document is postmarked. Requests submitted by facsimile or "fax" are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped by the division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

(27) **"Managed care organization"** or "MCO" means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

(28) **"Medical provider"** means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.

(29) **"Medical service"** means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.

(30) **"Medical service provider"** means a person duly licensed to practice one or more of the healing arts.

(31) **"Medical treatment"** means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker's condition through conservative care.

(32) **"Parties"** mean the worker, insurer, MCO, attending physician, and other medical provider, unless a specific limitation or exception is expressly provided for in the statute.

(33) **"Patient"** means the same as worker as defined in ORS 656.005(28).

(34) **"Physical capacity evaluation"** means an objective, directly observed, measurement of a patient's ability to perform a variety of physical tasks combined with subjective analyses of abilities by patient and evaluator. Physical tolerance screening, Blankenship's Functional Capacity Evaluation, and Functional Capacity Assessment have the same meaning as Physical Capacity Evaluation.

(35) **"Provider network"** means a health service intermediary other than an MCO that facilitates transactions between medical providers and insurers through a series of contractual arrangements.

(36) **"Report"** means medical information transmitted in written form containing relevant subjective or objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the director.

(37) **"Residual functional capacity"** means a patient's remaining ability to perform work-related activities. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the patient can perform each activity.

(38) **"Specialist physician"** means a licensed physician who qualifies as an attending physician and who examines a patient at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice or an opinion regarding the treatment being rendered, or considered, for a patient's compensable injury.

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OREGON MEDICAL FEE AND PAYMENT**

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Order No.
25-050**

(39) "Type A attending physician" means an attending physician under ORS 656.005(12)(b)(A). See Appendix A, "Matrix for Health Care Provider Types."

(40) "Type B attending physician" means an attending physician under ORS 656.005(12)(b)(B). See Appendix A, "Matrix for Health Care Provider Types."

(41) "Usual fee" means the medical provider's fee charged to the general public for a given service.

(42) "Work capacity evaluation" means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work Tolerance Screening has the same meaning as Work Capacity Evaluation.

(43) "Work hardening" means an individualized, medically prescribed and monitored, work-oriented treatment process. The process involves the patient participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the patient to a specific job.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.000 et seq.; 656.005; 656.726(4)

Hist: Amended 3/2/22 as Admin. Order 22-050, eff. 4/1/22
Amended 11/22/23 as Admin. Order 23-054, eff. 1/1/24

436-009-0008 Request for Review before the Director

(1) General.

(a) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all disputes concerning medical fees, nonpayment of compensable medical bills, and medical service and treatment disputes arising under ORS 656.245, 656.247, 656.248, 656.260, 656.325, and 656.327. Disputes about whether a medical service provided after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c), or whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review before the director.

(b) As provided in ORS 656.704(3)(b), the following disputes are in the jurisdiction of the board and will be transferred:

(A) A dispute that requires a determination of the compensability of the medical condition for which medical services are proposed; and

(B) A dispute that requires a determination of whether a sufficient causal relationship exists between medical services and an accepted claim.

(c) A party does not need to be represented to participate in the administrative review before the director.

(d) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed.

(e) A request for administrative review under this rule may also be filed as prescribed in OAR 438-005.

(2) Time Frames and Conditions.

The following time frames and conditions apply to requests for administrative review before the director under this rule:

(a) For MCO-enrolled claims, a party that disagrees with an action or decision of the MCO must first use the MCO's dispute resolution process. If the party does not appeal the MCO's decision using the MCO's dispute resolution process, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision absent a showing of good cause. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision.

When a party mistakenly sends an appeal of an MCO action or decision to the division, the division will forward the appeal to the MCO. The MCO must use the original mailing date of the appeal mistakenly sent to the division when determining timeliness of the appeal.

(b) For MCO-enrolled claims, if a party disagrees with the final action or decision of the MCO, the aggrieved party must request administrative review before the director within 60 days of the MCO's final decision. When the aggrieved party is a represented worker and the worker's attorney had given written notice of representation to the insurer at the time the MCO issued its decision, the 60-day time frame begins when the MCO issues its final decision to the attorney. If a party has been denied access to the MCO dispute resolution process, or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process. If the MCO does not have a process for resolving a particular type of dispute, the insurer or the MCO must advise the medical provider or worker that they may request review before the director.

(c) For claims not enrolled in an MCO, or for disputes that do not involve an action or decision of an MCO:

(A) A worker must request administrative review before the director within 90 days of the date the worker knew, or should have known, there was a dispute over the provision of medical services. If the worker is represented, and the worker's attorney has given notice of representation to the insurer, the 90-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute.

(B) A medical provider must request administrative review within 90 days of the mailing date of the most recent explanation of benefits or a similar notification the provider received regarding the disputed service or fee. Rebillings without any relevant changes will not provide a new 90-day period to request administrative review.

(C) An insurer must request administrative review within 90 days of the date action on the bill was due under OAR 436-009-0030.

(D) For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, whichever occurs last.

(d) Within 180 days of the date a bill is paid, an insurer may request a refund from a provider for any amount it determines

was overpaid for a compensable medical service. If the provider does not respond to the request, or disagrees that a service was overpaid, the insurer may request director review within 90 days of requesting the refund.

(e) Medical provider bills for treatment or services that are under review before the director are not payable during the review.

(3) Form and Required Information.

(a) Requests for administrative review before the director should be made on [Form 2842](#) as described in [Bulletin 293](#). When an insurer or a worker's representative submits a request without the required information, the director may dismiss the request or hold initiation of the administrative review until the required information is submitted. Unrepresented workers may ask the director for help in meeting the filing requirements.

(A) The requesting party must simultaneously notify all other interested parties and their representatives, if known, of the dispute. The notice must:

- (i) Identify the worker's name, date of injury, insurer, and claim number;
- (ii) Specify the issues in dispute and the relief sought; and
- (iii) Provide the specific dates of the unpaid disputed treatment or services.

(B) If the request for review is submitted by either the insurer or the medical provider, it must state specific codes of services in dispute and include enough documentation to support the request, including copies of original bills, chart notes, bill analyses, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to review the dispute. The insurer or medical provider requesting review must provide all involved parties a copy of:

- (i) The request for review;
- (ii) Any attached supporting documentation; and
- (iii) If known, an indication of whether or not there is an issue of causation or compensability under subsection (1)(b) of this rule.

(b) In addition to medical evidence relating to the dispute, all parties may submit other relevant information, including written factual information, sworn affidavits, or legal argument for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain additional evidence consistent with statute, such as pertinent medical treatment and payment records. The director may also interview parties to the dispute or consult with an appropriate committee of the medical provider's peers. When a party receives a written request for additional information from the director, the party must respond within 14 days.

(c) When a request for administrative review is filed under ORS 656.247, the insurer must provide a record packet, at no charge, to the director and all other parties or their representatives as follows:

(A) The packet must include a complete copy of the worker's medical record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top. The packet must include the following notice in bold type:

We hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order that could affect reimbursement for the disputed medical service(s).

(B) If the insurer requests review, the packet must accompany the request with copies sent simultaneously to the other parties.

(C) If the requesting party is other than the insurer or if the director has initiated the review, the director will request the record from the insurer. The insurer must provide the record within 14 days of the director's request as described in this rule.

(D) If the insurer fails to submit the record in the time and format specified in this rule, the director may sanction the insurer under OAR 436-010-0340.

(4) Dispute Resolution by Agreement (Alternative Dispute Resolution).

(a) A dispute may be resolved by agreement between the parties to the dispute. The agreement must be in writing and approved by the director. The director may issue a letter of agreement instead of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:

- (A) A party fails to honor the agreement;
 - (B) The agreement was based on misrepresentation;
 - (C) Implementation of the agreement is not feasible because of unforeseen circumstances; or
 - (D) All parties request revision or reinstatement of the dispute.
- (b) Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney.

(5) Director Order and Reconsideration.

(a) The director may, on the director's own motion, reconsider or withdraw 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 information that 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 must be received by the director before the administrative order becomes final.

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

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

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(d) Attorney fees in administrative review will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 through 436-001-0440.

(6) Hearings.

(a) Any party that disagrees with an action or administrative order under these rules may obtain review of the action or order by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order under ORS 656.245, 656.248, 656.260, or 656.327, or within 60 days of the mailing date of an order under ORS 656.247. OAR 436-001 applies to the hearing.

(b) In the review of orders issued under ORS 656.245(3) or 656.247, no new medical evidence or issues will be admitted at hearing. In these reviews, an administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(c) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254 or 656.745 may request a hearing by the board as follows:

(A) A written request for a hearing must be mailed or submitted to the division. The request must specify the grounds upon which the proposed order or assessment is contested.

(B) The request must be mailed or submitted to the division within 60 days after the mailing date of the order or notice of assessment.

(C) The division will forward the request and other pertinent information to the board.

(7) Other Proceedings.

(a) Director's administrative review of other actions not covered under sections (1) through (6) of this rule: Any party seeking an action or decision by the director, or any party aggrieved by an action taken by another party, may request administrative review before the director. Any party may request administrative review as follows:

(b) A written request for review must be sent to the division within 90 days of the disputed action and must specify the grounds upon which the action is contested.

(c) The division may require and allow such input and information as it deems appropriate to complete the review.

Stat. Auth.: ORS 656.704, 656.726(4)

Stats. Implemented: ORS 656.704

Hist: Amended 12/17/19 as Admin. Order 19-060, eff. 1/1/20

436-009-0010 Medical Billing and Payment

(1) General.

(a) Only treatment that falls within the scope and field of the medical provider's license to practice will be paid under a workers' compensation claim.

Except for emergency services or as otherwise provided for by statute or these rules, treatments and medical services are only payable if approved by the worker's attending physician or authorized nurse practitioner.

Fees for services by more than one physician at the same time are payable only when the services are sufficiently different that separate medical skills are needed for proper care.

(b) All billings must include the patient's full name, date of injury, and the employer's name. If available, billings must also include the insurer's claim number and the provider's NPI. If the provider does not have an NPI, then the provider must provide its license number and the billing provider's FEIN. For provider types not licensed by the state, "99999" must be used in place of the state license number. Bills must not contain a combination of ICD-9 and ICD-10 codes.

(c) The medical provider must bill their usual fee charged to the general public. The submission of the bill by the medical provider is a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The director may require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public. For purposes of this rule, "general public" means any person who receives medical services, except those persons who receive medical services subject to specific billing arrangements allowed under the law that require providers to bill other than their usual fee.

(d) Medical providers must not submit false or fraudulent billings, including billing for services not provided. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. A request for pre-payment for a deposition is not considered false or fraudulent.

(e) When a provider treats a patient with two or more compensable claims, the provider must bill individual medical services for each claim separately.

(f) When rebilling, medical providers must indicate that the charges have been previously billed.

(g) If a patient requests copies of medical bills in writing, medical providers must provide copies within 30 days of the request, and provide any copies of future bills during the regular billing cycle.

(2) Billing Timelines. (For payment timelines see OAR 436-009-0030.)

(a) Medical providers must bill within:

(A) 60 days of the date of service;

(B) 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or

(C) 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer.

(b) If the provider bills past the timelines outlined in subsection (a) of this section, the provider may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.

(c) When submitting a bill later than outlined in subsection (a) of this section, a medical provider must establish good cause.

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(d) When a provider submits a bill within 12 months of the date of service, the insurer may not reduce payment due to late billing.

(e) When a provider submits a bill more than 12 months after the date of service, the bill is not payable, except when a provision of subsection (2)(a) is the reason the billing was submitted after 12 months.

(3) Billing Forms.

(a) All medical providers must submit bills to the insurer unless a contract directs the provider to bill the managed care organization (MCO).

(b) Medical providers must submit bills on a completed current UB-04 (CMS 1450) or CMS 1500 except for:

(A) Dental billings, which must be submitted on American Dental Association dental claim forms;

(B) Pharmacy billings, which must be submitted on a current National Council for Prescription Drug Programs (NCPDP) form; or

(C) Electronic billing transmissions of medical bills (see OAR 436-008).

(c) Notwithstanding subsection (3)(b) of this rule, a medical service provider doing an IME may submit a bill in the form or format agreed to by the insurer and medical service provider.

(d) Medical providers may use computer-generated reproductions of the appropriate forms.

(e) Unless different instructions are provided in the table below, the provider should use the instructions provided in the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual.

Box Reference Number	Instruction
10d	May be left blank
11a, 11b, and 11c	May be left blank
17a	May be left blank if box 17b contains the referring provider's NPI
21	For dates of service prior to Oct. 1, 2015, use ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, use ICD-10-CM codes.
22	May be left blank
23	May be left blank
24D	The provider must use the following codes to accurately describe the services rendered: <ul style="list-style-type: none"> • CPT® codes listed in CPT® 2025; • Oregon Specific Codes (OSCs); or • HCPCS codes, only if there is no specific CPT® or OSC. If there is no specific code for the medical service: <ul style="list-style-type: none"> • The provider should use an appropriate unlisted code from CPT® 2025 (e.g., CPT® code 21299) or an unlisted code from HCPCS (e.g., HCPCS code E1399); and • The provider should describe the service provided. Nurse practitioners and physician associates must use modifier "81" when billing as the surgical assistant during surgery.
24I (shaded area)	See under box 24J shaded area.
24J (nonshaded area)	The rendering provider's NPI.
24J (shaded area)	If the bill includes the rendering provider's NPI in the nonshaded area of box 24J, the shaded area of box 24I and 24J may be left blank. If the rendering provider does not have an NPI, then include the rendering provider's state license number and use the qualifier "0B" in box 24I.
32	If the facility name and address are different than the billing provider's name and address in box 33, fill in box 32.
32a	If there is a name and address in box 32, box 32a must be filled in even if the NPI is the same as box 33a.

(4) Billing Codes.

(a) When billing for medical services, a medical provider must use codes listed in CPT® 2025 or Oregon specific codes (OSC) listed in OAR 436-009-0060 that accurately describe the service.

If there is no specific CPT® code or OSC, a medical provider must use the appropriate HCPCS or dental code, if available, to identify the medical supply or service.

If there is no specific code for the medical service, the medical provider must use the unlisted code at the end of each medical service section of CPT® 2025, or the appropriate unlisted HCPCS code, and provide a description of the service provided.

A medical provider must include the National Drug Code (NDC) to identify the drug or biological when billing for pharmaceuticals.

(b) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.

(5) Modifiers.

(a) When billing, unless otherwise provided by these rules, medical providers must use the appropriate modifiers found in CPT® 2025, HCPCS' level II national modifiers, or anesthesia modifiers, when applicable.

(b) Modifier 22 identifies a service provided by a medical service provider that requires significantly greater effort than typically required. Modifier 22 may only be reported with surgical procedure codes with a global period of 0, 10, or 90 days as listed in Appendix B. The bill must include documentation describing the additional work. It is not sufficient to simply document the extent of the patient's comorbid condition that caused the additional work. When a medical service provider appropriately bills for an eligible procedure with modifier 22, the payment rate is 125% of the fee published in Appendix B, or the fee billed, whichever is less. For all services identified by modifier 22, two or more of the following factors must be present:

- (A) Unusually lengthy procedure;
- (B) Excessive blood loss during the procedure;
- (C) Presence of an excessively large surgical specimen (especially in abdominal surgery);
- (D) Trauma extensive enough to complicate the procedure and not billed as separate procedure codes;
- (E) Other pathologies, tumors, malformations (genetic, traumatic, or surgical) that directly interfere with the procedure but are not billed as separate procedure codes; or
- (F) The services rendered are significantly more complex than described for the submitted CPT®.

(6) Physician Associates and Nurse Practitioners.

Physician associates and nurse practitioners must document in the chart notes that they provided the medical service. If physician associates or nurse practitioners provide services as surgical assistants during surgery, they must bill using modifier "81."

(7) Chart Notes.

(a) All original medical provider billings must be accompanied by legible chart notes. The chart notes must document the services that have been billed and identify the person performing the service.

(b) Chart notes must not be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(c) When processing electronic bills, the insurer may waive the requirement that bills be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. Medical providers may submit their chart notes separately or at regular intervals as agreed with the insurer.

(8) Challenging the Provider's Bill.

For services where the fee schedule does not establish a fixed dollar amount, an insurer may challenge the reasonableness of a provider's bill on a case by case basis by asking the director to review the bill under OAR 436-009-0008. If the director determines the amount billed is unreasonable, the director may establish a different fee to be paid to the provider based on at least one of, but not limited to, the following: reasonableness, the usual fees of similar providers, fees for similar services in similar geographic regions, or any extenuating circumstances.

(9) Billing the Patient and Patient Liability.

(a) A patient is not liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer according to OAR chapter 436, and a medical provider must not attempt to collect payment for any medical service from a patient, except as follows:

(A) If the patient seeks treatment for conditions not related to the accepted compensable injury or illness;

(B) If the patient seeks treatment or a service that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but is not limited to, ongoing treatment by nonattending physicians in excess of the 30-day/12-visit period or by nurse practitioners in excess of the 180-day period, as set forth in ORS 656.245 and OAR 436-010-0210;

(C) If the insurer notifies the patient that they are medically stationary and the patient seeks palliative care that is not authorized by the insurer or the director under OAR 436-010-0290;

(D) If an MCO-enrolled patient seeks treatment from the provider outside the provisions of a governing MCO contract; or

(E) If the patient seeks treatment listed in section (12) of this rule after the patient has been notified that such treatment is unscientific, unproven, outmoded, or experimental.

(b) If the director issues an order declaring an already rendered medical service or treatment inappropriate, or otherwise in violation of the statute or administrative rules, the worker is not liable for such services.

(c) A provider may bill a patient for a missed appointment under section (13) of this rule.

(10) Disputed Claim Settlement (DCS).

The insurer must pay a medical provider for any bill related to the claimed condition received by the insurer on or before the date the terms of a DCS were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS, except, if the DCS payments have already been made, the payment must not be deducted from the settlement proceeds. Payment must be made within 45 days of the insurer's knowledge of the outstanding bill.

(11) Payment Limitations.

(a) Insurers do not have to pay providers for the following:

(A) Completing form [827](#);

(B) Providing chart notes with the original bill;

(C) Preparing a written treatment plan;

(D) Supplying progress notes that document the services billed;

(E) Completing a work release form or completion of a PCE form, when no tests are performed;

(F) A missed appointment "no show" (see exceptions below under section (13) Missed Appointment "No Show"); or

(G) More than three mechanical muscle testing sessions per treatment program or when not prescribed and approved by the attending physician or authorized nurse practitioner.

(b) Mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient. Additional mechanical muscle testing may be paid for only when authorized in writing by the insurer prior to the testing.

(c) Dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the patient.

(d) Vitamin B-12 injections are not reimbursable unless necessary for a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.

(12) Excluded Treatment.

The following medical treatments (or treatment of side effects) are not compensable and insurers do not have to pay for:

(a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;

(b) Intradiscal electrothermal therapy (IDET);

(c) Surface electromyography (EMG) tests;

(d) Rolting;

(e) Prolotherapy;

(f) Thermography;

(g) Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:

(A) The single level artificial disc replacement is between L3 and S1;

(B) The patient is 16 to 60 years old;

(C) The patient underwent a minimum of six months unsuccessful exercise based rehabilitation; and

(D) The procedure is not found inappropriate under OAR 436-010-0230;

(h) Cervical artificial disc replacement, unless the procedure is a single level or a two level contiguous cervical artificial disc replacement with a device that has Food and Drug Administration (FDA) approval for the procedure; and

(i) Platelet rich plasma (PRP) injections, unless they are for non-operative:

(A) Knee: Osteoarthritis pain, chondral surface injury and partial thickness meniscal tears after failure of three months of conservative care, which may include a standard course of physical therapy;

(B) Elbow: Lateral and medial epicondylitis after failure of three months of conservative care, which may include a standard course of physical therapy; or

(C) Shoulder: Tendon, bursa, and muscle injuries, including partial tears and small tears, and adhesive capsulitis after failure of three months of conservative care, which may include a standard course of physical therapy.

(13) Missed Appointment (No Show).

(a) In general, the insurer does not have to pay for "no show" appointments. However, insurers must pay for "no show" appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams. If the patient does not give 48 hours notice, the insurer must pay the provider 50 percent of the exam or testing fee and 100 percent for any review of the file that was completed prior to cancellation or missed appointment.

(b) Other than missed appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams, a provider may bill a patient for a missed appointment if:

(A) The provider has a written missed-appointment policy that applies not only to workers' compensation patients, but to all patients;

(B) The provider routinely notifies all patients of the missed-appointment policy;

(C) The provider's written missed-appointment policy shows the cost to the patient; and

(D) The patient has signed the missed-appointment policy.

(c) The implementation and enforcement of subsection (b) of this section is a matter between the provider and the patient. The division is not responsible for the implementation or enforcement of the provider's policy.

Stat. Auth.: ORS 656.245, 656.248, 656.252, 656.254, 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254

Hist: Amended 12/9/25 as Admin. Order 24-055, eff. 1/1/25 Temp

Amended 3/11/25 as Admin. Order 24-050, eff. 4/1/25

436-009-0012 Telehealth

(1) Definitions.

(a) For the purpose of this rule, "telehealth" means providing healthcare remotely by means of telecommunications technology, including but not limited to telemedicine and telephonic or online digital services.

(b) For the purpose of this rule, "telemedicine" means synchronous medical services provided via a real-time interactive audio and video telecommunications system between a patient at an originating site and a provider at a distant site.

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(c) "Distant site" means the place where the provider providing medical services to a patient through telehealth is located.

(d) "Originating site" means the place where the patient receiving medical services through telehealth is located.

(2) Scope of services.

(a) All services must be appropriate, and the form of communication must be appropriate for the service provided.

(b) Notwithstanding OAR 436-009-0004, medical services that may be provided through telemedicine are not limited to those listed in Appendix P of CPT® 2025.

(3) Distant site provider billing.

(a) When billing for telemedicine services, the distant site provider must:

(A) Use the place of service (POS) code "02" (Telehealth Provided Other than in Patient's Home) or "10" (Telehealth Provided in Patient's Home); and

(B) Except for services billed with CPT® codes 98000 – 98007, use modifier 95 to identify the service as a synchronous medical service rendered via a real-time interactive audio and video telecommunications system.

(b) When billing for telehealth services other than telemedicine services, the distant site provider:

(A) Must use the POS code "02" (Telehealth Provided Other than in Patient's Home) or "10" (Telehealth Provided in Patient's Home); and

(B) May not use modifier 95.

(4) Originating site billing.

When billing for telehealth services, the originating site may charge a facility fee using HCPCS code Q3014, if the site is:

(a) The office of a physician or practitioner; or

(b) A health care facility including but not limited to a hospital, rural health clinic, skilled nursing facility, or community mental health center.

(5) Payment.

(a) Insurers must pay distant site providers at the non-facility rate or at the provider's usual fee, whichever is less.

(b) Equipment or supplies at the distant site are not separately payable.

(c) The payment amount for code Q3014 is \$35.70 per unit or the provider's usual fee, whichever is lower. In calculating the units of time, 15 minutes, or any portion of 15 minutes, equals one unit.

(d) Professional fees of supporting providers at the originating site are not separately payable.

(e) Insurers are not required to pay a telehealth transmission fee (HCPCS code T1014).

Stat. Auth.: ORS 726(4), 656.245, 656.248, 656.252, 656.254
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254
Hist: Amended 12/9/25 as Admin. Order 24-055, eff. 1/1/25 Temp
Amended 3/11/25 as Admin. Order 24-050, eff. 4/1/25

436-009-0018 Discounts and Contracts

(1) Discounts.

(a) An insurer may only apply the following discounts to a medical service provider's or clinic's fee:

(A) A fee agreed to under a fee discount agreement that conforms to this rule and has been reported to the director; or

(B) A fee agreed to by the medical service provider or clinic under an MCO contract to cover services provided to a worker enrolled in the MCO.

(b) If the insurer has multiple contracts with a medical service provider or clinic, and one of the contracts is through an MCO for services provided to an enrolled worker, the insurer may only apply the discount under the MCO's contract.

(c) Any discount under a fee discount agreement cannot be more than 10 percent of the fee schedule amount.

(d) An insurer may not apply a fee discount until the medical service provider or clinic and the insurer have signed the fee discount agreement.

(2) Fee Discount Agreements.

(a) The fee discount agreement between the parties must be on the provider's letterhead and contain all the information listed on [Form 3659](#). [Bulletin 352](#) provides further information. The agreement must include the following:

(A) A statement that the medical service provider or clinic understands and voluntarily agrees with the terms of the fee discount agreement;

(B) The effective and end dates of the agreement;

(C) The discount rate or rates under the agreement;

(D) A statement that the insurer or employer may not direct patients to the provider or clinic, and that the insurer or employer may not direct or manage the care a patient receives;

(E) A statement that the agreement only applies to patients who are being treated for Oregon workers' compensation claims;

(F) A statement that the fee discount agreement may not be amended. A new fee discount agreement must be executed to change the terms between the parties;

(G) A statement that either party may terminate the agreement by providing the other party with 30 days written notice;

(H) The name and address of the singular insurer or self-insured employer that will apply the discounts;

(I) The national provider identifier (NPI) for the provider or clinic; and

(J) Other terms and conditions to which the medical service provider or clinic and the insurer agree and that are consistent with these rules.

(b) Once the fee discount agreement has been signed by the insurer and medical service provider or clinic, the insurer must report the fee discount agreement to the director by completing the director's online form. The following information must be included:

(A) The insurer's name that will apply the discounts under the fee discount agreement;

(B) The medical service provider's or clinic's name;

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- (C) The effective date of the agreement;
(D) The end date of the agreement;
(E) The discount rate under the agreement; and
(F) An indication that all the terms required under section (2)(a) of this rule are included in the signed fee discount agreement.

(3) Fee Discount Agreement Modifications and Terminations.

(a) When the medical service provider or clinic and the insurer agree to modify an existing fee discount agreement, the parties must enter into a new fee discount agreement.

(b) Either party to the fee discount agreement may terminate the agreement by providing 30 days written notice to the other party. The insurer must report the termination to the director prior to the termination taking effect by completing the director's online form. The following information must be reported:

- (A) The insurer's name;
(B) The medical service provider's or clinic's name; and
(C) The termination date of the agreement.

(4) Other Medical Providers.

(a) For the purpose of this rule, "other medical providers" means providers such as hospitals, ambulatory surgery centers, or vendors of medical services and does not include medical service providers or clinics.

(b) The insurer may apply a discount to the medical provider's fee if a written or verbal contract exists.

(c) If the insurer and the medical provider have multiple contracts, only one discount may be applied.

(d) If the insurer has multiple contracts with a provider and one of the contracts is through an MCO for services provided to an enrolled worker, the insurer may only apply the discount under the MCO's contract.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.248

Hist: Amended 3/11/19 as Admin. Order 19-051, eff. 4/1/19

436-009-0020 Hospitals

(1) Inpatient.

(a) For the purposes of this rule, hospital inpatient services are those services that are billed with codes "0111" through "0118" in form locator #4 on the UB-04 billing form.

(b) Hospital inpatient bills must include:

(A) For dates of service prior to Oct. 1, 2015, ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, ICD-10-CM codes;

(B) When applicable, procedural codes;

(C) The hospital's NPI; and

(D) The Medicare Severity Diagnosis Related Group (MS-DRG) code, except for:

- (i) Bills from critical access hospitals, (See [Bulletin 290](#)); or
(ii) Bills containing revenue code 002x.

(c) Unless otherwise provided by contract, the insurer must pay the audited bill for hospital inpatient services by multiplying the amount charged by the hospital's adjusted cost-to-charge ratio (See [Bulletin 290](#)). The insurer must pay in-state hospitals not listed in Bulletin 290 at 80 percent of billed charges for inpatient services.

(2) Outpatient.

(a) For the purposes of this rule, hospital outpatient services are those services that are billed with codes "0131" through "0138" in form locator #4 on the UB-04 billing form.

(b) Hospital outpatient bills must, when applicable, include the following:

(A) Revenue codes;

(B) For dates of service prior to Oct. 1, 2015, ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, ICD-10-CM codes,

(C) CPT® codes and HCPCS codes; and

(D) The hospital's NPI.

(c) Unless otherwise provided by contract, the insurer must pay for hospital outpatient services as follows:

:

Revenue Code	Pay Amount:	
0320-0359 0400-0409 0420-0449 0610-0619	Lesser of:	Non-facility column in Appendix B or
		The amount billed
0960-0989	Lesser of:	Facility column in Appendix B or
		The amount billed
All other revenue codes	<ul style="list-style-type: none"> For hospitals listed in Bulletin 290, the amount billed multiplied by the cost-to-charge ratio. For in-state hospitals not listed in Bulletin 290, 80% of the amount billed. For out-of-state hospitals, the amount billed multiplied by a cost-to-charge ratio of 1.000. 	

(3) Specific Circumstances.

When a patient is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission are considered part of the inpatient treatment. Diagnostic testing done prior to inpatient treatment is considered part of the hospital services subject to the hospital inpatient fee schedule.

(4) Out-of-State Hospitals.

(a) Unless otherwise agreed upon by the hospital and the insurer, insurers must pay an out-of-state hospital for inpatient services as outlined in subsection (1)(c) of this rule and for outpatient services as outlined in subsection (2)(c) of this rule.

(b) The payment to out-of-state hospitals may be negotiated between the insurer and the hospital.

(c) Any agreement for payment less than the Oregon fee schedule amount must be in writing and signed by the hospital and insurer representative.

(d) The agreement must include language that the hospital will not bill the patient any remaining balance and that the negotiated amount is considered payment in full.

(e) Notwithstanding OAR 436-009-0010(8), if the insurer and the hospital are unable to reach an agreement within 45 days of the insurer's receipt of the bill, the insurer must pay an out-of-state hospital for inpatient services as outlined in subsection (1)(c) of this rule and for outpatient services as outlined in subsection (2)(c) of this rule.

(5) Calculation of Cost-to-Charge Ratio Published in Bulletin 290.

(a) Each hospital's CMS 2552 form and financial statement is the basis for determining its adjusted cost-to-charge ratio. If a current form 2552 is not available, then financial statements may be used to develop estimated data. If the adjusted cost-to-charge ratio is determined from estimated data, the hospital will receive the lower ratio of either the hospital's last published cost-to-charge ratio or the hospital's cost-to-charge ratio based on estimated data.

(b) The basic cost-to-charge ratio is developed by dividing the total net expenses for allocation shown on Worksheet A, and as modified in subsection (c), by the total patient revenues from Worksheet G-2.

(c) The net expenses for allocation derived from Worksheet A is modified by adding, from Worksheet A-8, the expenses for:

(A) Provider-based physician adjustment;

(B) Patient expenses such as telephone, television, radio service, and other expenses determined by the director to be patient-related expenses; and

(C) Expenses identified as for physician recruitment.

(d) The basic cost-to-charge ratio is further modified to allow a factor for bad debt and the charity care provided by each hospital. The adjustment for bad debt and charity care is calculated in two steps. Step one: Add the dollar amount for net bad debt to the dollar amount for charity care. Divide this sum by the dollar amount of the total patient revenues, from Worksheet G-2, to compute the bad debt and charity ratio. Step

two: Multiply the bad debt and charity ratio by the basic cost-to-charge ratio calculated in subsection (5)(b) to obtain the factor for bad debt and charity care.

(e) The basic cost-to-charge ratio is further modified to allow an adequate return on assets. The director will determine a historic real growth rate in the gross fixed assets of Oregon hospitals from the audited financial statements. This real growth rate and the projected growth in a national fixed weight price deflator will be added together to form a growth factor. This growth factor will be multiplied by the total fund balance, from Worksheet G of each hospital's CMS 2552 to produce a fund balance amount. The fund balance amount is then divided by the total patient revenues from Worksheet G-2, to compute the fund balance factor.

(f) The factors resulting from subsections (5)(d) and (5)(e) of this rule are added to the ratio calculated in subsection (5)(b) of this rule to obtain the adjusted cost-to-charge ratio. In no event will the adjusted cost-to-charge ratio exceed 1.00.

(g) The adjusted cost-to-charge ratio for each hospital will be revised annually, at a time based on their fiscal year, as described by bulletin. Each hospital must submit a copy of its CMS 2552 and financial statements each year within 150 days of the end of the hospital's fiscal year to the Information Technology and Research Section, Department of Consumer and Business Services. The adjusted cost-to-charge ratio schedule will be published by bulletin yearly.

(h) For newly formed or established hospitals for which no CMS 2552 has been filed or for which there is insufficient data, or for those hospitals that do not file Worksheet G-2 with the submission of their CMS 2552, the division determines an adjusted cost-to-charge ratio for the hospital based upon the adjusted cost to charge ratios of a group of hospitals of similar size or geographic location.

(i) If the financial circumstances of a hospital unexpectedly or dramatically change, the division may revise the hospital's adjusted cost-to-charge ratio to allow equitable payment.

(j) If audit of a hospital's CMS 2552 by the CMS produces significantly different data from that obtained from the initial filing, the division may revise the hospital's adjusted cost-to-charge ratio to reflect the data developed subsequent to the initial calculation.

(k) Notwithstanding subsections (1)(c) and (2)(c) of this rule, the director may exclude rural hospitals from imposition of the adjusted cost-to-charge ratio based upon a determination of economic necessity. The rural hospital exclusion will be based on the financial health of the hospital reflected by its financial flexibility index. All rural hospitals having a financial flexibility index at or below the median for all Oregon critical access hospitals qualify for the rural exemption. Rural hospitals that are designated as critical access hospitals under the Oregon Medicare Rural Hospital Flexibility Program are automatically exempt from imposition of the adjusted cost-to-charge ratio.

Stat. Auth.: ORS 656.726(4), also see 656.012, 656.236(5), 656.327(2), 656.313(4)(d)

Stats. Implemented: ORS 656.248; 656.252; 656.256

Hist: Amended 3/9/23 as Admin. Order 23-050, eff. 4/1/23

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436-009-0023 Ambulatory Surgery Center (ASC)

(1) Billing Form.

(a) The ASC must submit bills on a completed, current CMS 1500 form (see OAR 436-009-0010 (3)) unless the ASC submits medical bills electronically. Computer-generated reproductions of the CMS 1500 form may also be used.

(b) The ASC must add a modifier "SG" in box 24D of the CMS 1500 form to identify the facility charges.

(2) ASC Facility Fee.

(a) The following services are included in the ASC facility fee and the ASC may not receive separate payment for them:

(A) Nursing, technical, and related services;

(B) Use of the facility where the surgical procedure is performed;

(C) Drugs and biologicals designated as packaged in Appendix D, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure;

(D) Radiology services designated as packaged in Appendix D;

(E) Administrative, record-keeping, and housekeeping items and services;

(F) Materials for anesthesia;

(G) Supervision of the services of an anesthetist by the operating surgeon; and

(H) Packaged services identified in Appendix C or D.

(b) The payment for the surgical procedure (i.e., the ASC facility fee) does not include physician's services, laboratory, X-ray, or diagnostic procedures not directly related to the surgical procedures, prosthetic devices, orthotic devices, durable medical equipment (DME), or anesthetists' services.

(3) ASC Billing.

(a) The ASC should not bill for packaged codes as separate line-item charges when the payment amount says "packaged" in Appendices C or D.

(b) When the ASC provides packaged services (see Appendices C and D) with a surgical procedure, the billed amount should include the charges for the packaged services.

(c) For the purpose of this rule, an implant is an object or material inserted or grafted into the body. When the ASC's cost for an implant is \$100 or more, the ASC may bill for the implant as a separate line item. The ASC must provide the insurer a receipt of sale showing the ASC's cost of the implant.

(4) ASC Payment.

(a) Unless otherwise provided by contract, insurers must pay ASCs for services according to this rule.

(b) Insurers must pay for surgical procedures (i.e., ASC facility fee) and ancillary services the lesser of:

(A) The maximum allowable payment amount for the HCPCS code found in Appendix C for surgical procedures, and in Appendix D for ancillary services integral to a surgical procedure; or

(B) The ASC's usual fee for surgical procedures and ancillary services.

(c) When more than one procedure is performed in a single operative session, insurers must pay the principal procedure at 100 percent of the maximum allowable fee, and the secondary and all subsequent procedures at 50 percent of the maximum allowable fee.

A diagnostic arthroscopic procedure performed preliminary to an open operation is considered a secondary procedure and should be paid accordingly.

The multiple surgery discount described in this section does not apply to codes listed in Appendix C with an "N" in the "Subject to Multiple Procedure Discounting" column.

(d) The table below lists packaged surgical codes that ASCs may perform without any other surgical procedure. In this case do not use Appendix C to calculate payment, use the rates listed below instead.

CPT® Code	Maximum Payment Amount	CPT® Code	Maximum Payment Amount
23350	\$235.12	36410	\$19.94
25246	\$220.99	36416	80% of billed
27093	\$304.90	36620	80% of billed
27648	\$274.16	62284	\$282.47
36000	\$39.05	62290	\$417.89

(e) When the ASC's cost of an implant is \$100 or more, insurers must pay for the implants at 110 percent of the ASC's actual cost documented on a receipt of sale and not according to Appendix D or E.

(f) When the ASC's cost of an implant is less than \$100, insurers are not required to pay separately for the implant. An implant may consist of several separately billable components,

some of which may cost less than \$100. For payment purposes, insurers must add the costs of all the components for the entire implant and use that total amount to calculate payment for the implant.

(g) The insurer does not have to pay the ASC when the ASC provides services to a patient who is enrolled in a managed care organization (MCO) and:

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- (A) The ASC is not a contracted facility for the MCO;
- (B) The MCO has not pre-certified the service provided; or
- (C) The surgeon is not an MCO panel provider.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245; 656.248; 656.252
Hist: Amended 12/9/25 as Admin. Order 24-055, eff. 1/1/25 Temp
Amended 3/11/25 as Admin. Order 24-050, eff. 4/1/25

436-009-0025 Worker Reimbursement

(1) General.

(a) When the insurer accepts the claim the insurer must notify the worker in writing that:

(A) The insurer will reimburse claim-related services paid by the worker; and

(B) The worker has two years to request reimbursement.

(b) The worker must request reimbursement from the insurer in writing. The insurer may require reasonable documentation such as a sales slip, receipt, or other evidence to support the request. The worker may use [Form 3921 – Request for Reimbursement of Expenses](#).

(c) Insurers must date stamp requests for reimbursement on the date received.

(d) The insurer or its representative must provide a written explanation to the worker for each type of out-of-pocket expense (mileage, lodging, medication, etc.) being paid or denied.

(e) The explanation to the worker must be in 10 point size font or larger and must include:

(A) The amount of reimbursement for each type of out-of-pocket expense requested.

(B) The specific reason for nonpayment, reduced payment, or discounted payment for each itemized out-of-pocket expense the worker submitted for reimbursement;

(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a worker's reimbursement question within two days, excluding Saturdays, Sundays, and legal holidays;

(D) The following notice, Web link, and phone number:

“To access [Bulletin 112](#) with information about reimbursement amounts for travel, food, and lodging costs visit wcd.oregon.gov or call 503-947-7606.”;

(E) Space for the worker's signature and date; and

(F) A notice of the right to administrative review in bold text and formatted as follows:

If you disagree with this decision about payment, contact {the insurer or its representative} first. If you still disagree about payment, you may request administrative review by the Department of Consumer and Business Services (DCBS). To request review, you must do all of the following:

- Submit your request within 90 days of the mailing date of this explanation**
- Sign and date this explanation in the space**

provided

- Explain why you think the payment is incorrect**
- Attach required supporting documentation of your expense**
- Send the documents to:**

**DCBS Workers' Compensation Division
Medical Resolution Team
350 Winter Street NE
PO Box 14480
Salem OR 97309-0405**

Or

**Fax your request to the Medical Resolution
Team at 503-947-7629**

- Send a copy of your request to the insurer**

Keep a copy of this document for your records.

(f) According to ORS 656.325(1)(f) and OAR 436-060-0095(4), when a worker attends an independent medical examination (IME), the insurer must reimburse the worker for related costs regardless of claim acceptance, deferral, or denial.

(2) Timeframes.

(a) The worker must submit a request for reimbursement of claim-related costs by whichever date is later:

(A) Two years from the date the costs were incurred or

(B) Two years from the date the claim or medical condition is finally determined compensable.

(b) The insurer may disapprove the reimbursement request if the worker requests reimbursement after two years as listed in subsection (a).

(c) On accepted claims the insurer must, within 30 days of receiving the reimbursement request, reimburse the worker if the request shows the costs are related to the accepted claim or disapprove the request if unreasonable or if the costs are not related to the accepted claim.

(A) The insurer may request additional information from the worker to determine if costs are related to the accepted claim within 30 days of receiving the reimbursement request.

(B) If additional information is needed, the time needed to obtain the information is not counted in the 30-day time frame for the insurer to issue reimbursement or disapprove the request.

(d) When the insurer receives a reimbursement request before claim acceptance, and the claim is ultimately accepted, the insurer must, within 30 days of receiving the reimbursement request or 14 days of claim acceptance, whichever is later, reimburse the worker if the request shows the costs are related to the accepted claim or disapprove the request if unreasonable or if the costs are not related to the accepted claim.

(A) The insurer may request additional information from the worker to determine if costs are related to the accepted claim within 30 days of receiving the reimbursement request or 14 days of claim acceptance, whichever is later.

(B) If additional information is needed, the time needed to obtain the information is not counted in the 30-day or 14-day time frame for the insurer to issue reimbursement or disapprove the request.

(e) When any action, other than those listed in subsections (c) and (d) of this section, causes the reimbursement request to be payable, the insurer must reimburse the worker within 14 days of the action.

(f) In a claim for aggravation or a new medical condition, reimbursement requests are not due and payable until the aggravation or new medical condition is accepted.

(g) If the claim is denied, requests for reimbursement must be returned to the worker within 14 days, and the insurer must retain a copy.

(3) Meal and Lodging Reimbursement.

(a) Meal reimbursement is based on whether a meal is reasonably required by necessary travel to a claim-related appointment.

(b) Lodging reimbursement is based on the need for an overnight stay to attend an appointment.

(c) Meals and lodging are reimbursed at the actual cost or the rate published in [Bulletin 112](#), whichever is less. Lodging reimbursement may exceed the maximum rate published in Bulletin 112 when special lodging is required or when the worker is unable to find lodging at or below the maximum rate within 10 miles of the appointment location. The reimbursement rates for meals and lodging expenses listed in Bulletin 112 are based on the rates published by the U.S. General Services Administration (GSA).

(4) Travel Reimbursement.

(a) Insurers must reimburse workers for actual and reasonable costs for travel to medical providers paid by the worker under ORS 656.245(1)(e), 656.325, and 656.327.

(b) The insurer may limit worker reimbursement for travel to an attending physician if the insurer provides a prior written explanation and a written list of attending physicians that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker.

The insurer may limit worker reimbursement for travel to an authorized nurse practitioner if the insurer provides a prior written explanation and a written list of authorized nurse practitioners that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker.

The insurer must inform the worker that the worker may continue treating with the established attending physician or authorized nurse practitioner; however, reimbursement of transportation costs may be limited to the distance from the worker's home to a provider on the written list.

(c) Within a metropolitan area the insurer may not limit worker reimbursement for travel to an attending physician or authorized nurse practitioner even if there are medical providers closer to the worker.

(d) Travel reimbursement dispute decisions will be based on principles of reasonableness and fairness within the context of the specific case circumstances as well as the spirit and intent of the law.

(e) Personal vehicle mileage is the reasonable actual distance based on the beginning and ending addresses. The mileage reimbursement is limited to the rate published in Bulletin 112. The reimbursement rates for mileage expenses listed in Bulletin 112 are based on the rates published by the U.S. General Services Administration (GSA).

(f) Public transportation or, if required, special transportation will be reimbursed based on actual cost.

(5) Other Reimbursements.

(a) The insurer must reimburse the worker for other claim-related expenses based on actual cost. However, reimbursement for hearing aids is limited to the amounts listed in OAR 436-009-0080.

(b) For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515.

When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must either pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy. The worker may then request reimbursement from the insurer. However, if the insurer has previously notified the worker in writing that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug.

(c) For IMEs, child care costs are reimbursed at the rate prescribed by the State of Oregon Department of Human Services.

(d) Home health care provided by a worker's family member is not required to be under the direct control and supervision of the attending physician. A worker may receive reimbursement for such home health care services only if the family member demonstrates competency to the satisfaction of the worker's attending physician.

(6) Advancement Request.

If necessary to attend a medical appointment, the worker may request an advance for transportation and lodging expenses. Such a request must be made to the insurer in sufficient time to allow the insurer to process the request.

Stat. Auth: ORS 656.245, 656.325, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.245, 656.704, and 656.726(4)
Hist: Amended 3/9/23 as Admin. Order 23-050, eff. 4/1/23
Amended 3/5/24 as Admin. Order 24-050, eff. 4/1/24
Amended 3/11/25 as Admin. Order 24-050, eff. 4/1/25

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436-009-0030 Insurer's Duties and Responsibilities

(1) General.

(a) The insurer must pay for medical services related to a compensable injury claim, except as provided by OAR 436-060-0055.

(b) The insurer, or its designated agent, may request from the medical provider any and all necessary records needed to review accuracy of billings. The medical provider may charge an appropriate fee for copying documents under OAR 436-009-0060. If the evaluation of the records must be conducted on-site, the provider must furnish a reasonable work-site for the records to be reviewed at no cost. These records must be provided or made available for review within 14 days of a request.

(c) The insurer must establish an audit program for bills for all medical services to determine that the bill reflects the services provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum fees adopted by the director, and that bills are submitted in a timely manner. The audit must be continuous and must include no fewer than 10 percent of medical bills.

The insurer must provide upon the director's request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation must include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.

(2) Bill Processing.

(a) Insurers must date stamp medical bills, chart notes, and other documentation upon receipt. Bills not submitted according to OAR 436-009-0010(1)(b), (3), and (7) must be returned to the medical provider within 20 days of receipt of the bill with a written explanation describing why the bill was returned and what needs to be corrected. A request for chart notes on EDI billings must be made to the medical provider within 20 days of the receipt of the bill.

The number of days between the date the insurer returns the bill or requests chart notes and the date the insurer receives the corrected bill or chart notes, does not count toward the 45 days within which the insurer is required to make payment.

(b) The insurer must retain a copy of each medical provider's bill received by the insurer or must be able to reproduce upon request data relevant to the bill, including but not limited to, provider name, date of service, date the insurer received the bill, type of service, billed amount, coding submitted by the medical provider as described in OAR 436-009-0010(1)(b) and (3)(b), and insurer action, for any nonpayment or fee reduction. This includes all bills submitted to the insurer even when the insurer determines no payment is due.

(c) Any service billed with a code number commanding a higher fee than the services provided must be returned to the medical provider for correction or paid at the value of the service provided.

(3) Payment Requirements.

(a) Insurers must pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the bill is submitted in proper form according to OAR 436-009-0010(1)(b), (3)(a) through (7)(c), and clearly shows that the treatment is related to the accepted compensable injury or disease.

(b) The insurer or its representative must provide a written explanation of benefits (EOB) of the services being paid or denied within 45 days of receipt of the bill. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. The insurer or its representative must send the explanation to the medical provider that billed for the services. For the purpose of this rule an EOB has the same meaning as an explanation of review (EOR).

(c) The written EOB must be in 10 point size font or larger. Electronic and written explanations must include:

(A) The amount of payment for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;

(B) The specific reason for nonpayment, reduced payment, or discounted payment for each service billed;

(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a medical provider's payment question within two days, excluding Saturdays, Sundays, and legal holidays;

(D) The following notice, Web link, and phone number:
"To access information about Oregon's Medical Fee and Payment Rules, visit

www.oregonwcdoc.info or call 503-947-7606.";

(E) Space for the provider's signature and date; and

(F) A notice of the right to administrative review in bold and formatted as follows:

If you disagree with this decision about payment, contact {the insurer or its representative} first. If you still disagree about payment, you may request administrative review by the Department of Consumer and Business Services (DCBS). To request review, you must do all of the following:

- Submit your request within 90 days of the mailing date of this explanation**
- Sign and date this explanation in the space provided**
- Explain why you think the payment is incorrect**
- Attach required supporting documentation of your expense**
- Send the documents to:**

**DCBS Workers' Compensation Division
Medical Resolution Team
350 Winter Street NE
PO Box 14480
Salem OR 97309-0405**

**OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
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Or

**Fax your request to the Medical Resolution
Team at 503-947-7629**

- Send a copy of your request to the insurer

Keep a copy of this document for your records.

(d) Payment of medical bills is required within 14 days of any action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later.

(e) Failure to pay for medical services timely may render the insurer liable to pay a reasonable monthly service charge for the period payment was delayed, if the provider customarily applies such a service charge to the general public.

(f) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for nonpayment or reduction of each medical service code.

(g) Bills for medical services rendered at the request of the insurer and bills for information submitted at the request of the insurer, which are in addition to those required in OAR 436-010-0240 must be paid within 45 days of receipt by the insurer even if the claim is denied.

(h) If an insurer determines that it has made an overpayment to a provider for medical services, the insurer may request a refund from the provider. The insurer must make the request within 180 days of the payment date. Resolution of overpayment disputes must be made under OAR 436-009-0008.

(4) Electronic Payment.

(a) An insurer may pay a provider through a direct deposit system, automated teller machine card or debit card, or other means of electronic transfer if the provider voluntarily consents.

(A) The provider's consent must be obtained before initiating electronic payments.

(B) The consent may be written or verbal. The insurer must send the provider a written confirmation when consent is obtained verbally.

(C) The provider may discontinue receiving electronic payments by notifying the insurer in writing.

(b) Cardholder agreement for ATM or debit cards.

The provider must receive a copy of the cardholder agreement outlining the terms and conditions under which an automated teller machine card or debit card has been issued before or at the time the initial electronic payment is made.

(c) Instrument of payment.

The instrument of payment must be negotiable and payable to the provider for the full amount of the benefit paid, without cost to the provider.

(5) Communication with Providers.

(a) The insurer or its representative must respond to a medical provider's inquiry about a medical payment within two days,

excluding Saturdays, Sundays, and legal holidays. The insurer or its representative may not refer the medical provider to another entity to obtain an answer.

(b) An insurer or its representative and a medical provider may agree to send and receive payment information by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 to 646A.628 and federal law.

(6) EDI Reporting.

For medical bill reporting requirements, see OAR 436-160 Electronic Data Interchange Medical Bill Data rules.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264

Hist: Amended 3/5/24 as Admin. Order 24-050, eff. 4/1/24

Amended 3/11/25 as Admin. Order 24-050, eff. 4/1/25

436-009-0035 Interim Medical Benefits

(1) General.

(a) Interim medical benefits under ORS 656.247 only apply to initial claims when the patient has a health benefit plan, i.e., the patient's private health insurance. For the purpose of this rule the Oregon Health Plan is not a health benefit plan.

(b) Interim medical benefits are not due on claims:

(A) When the patient is enrolled in an MCO prior to claim acceptance or denial under ORS 656.245(4)(b)(B); or

(B) When the insurer denies the claim within 14 days of the employer's notice of the claim.

(c) Interim medical benefits cover services provided from the date of employer's notice or knowledge of the claim to the date the insurer accepts or denies the claim. Interim medical benefits do not include treatments excluded under OAR 436-009-0010(12).

(d) When billing for interim medical benefits, the medical provider must bill the workers' compensation insurer according to these rules, and the health benefit plan according to the plan's requirements. The provider may submit a pre-authorization request to the health benefit plan prior to claim acceptance or denial.

(e) If the medical provider knows that the patient filed a work-related claim, the medical provider may not collect any health benefit plan co-pay, co-insurance, or deductible from the patient during the interim period.

(2) Claim Acceptance.

If the insurer accepts the claim:

(a) The insurer must pay medical providers for services according to these rules; and

(b) The provider, after receiving payment from the insurer, must reimburse the worker and the health benefit plan for any medical expenses, co-pays, co-insurance, or deductibles, paid by the worker or the health benefit plan.

(3) Claim Denial.

If the insurer denies the claim:

(a) The insurer must notify the medical provider as provided in OAR 436-060-0140 that an initial claim has been denied; and

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(b) The medical provider must bill the health benefit plan, unless the medical provider has previously billed the health benefit plan. The provider must forward a copy of the workers' compensation denial letter to the health benefit plan.

Stat. Auth: ORS 656.245, 656.704, and 656.726(4)
Stat. Implemented: ORS 656.247
Hist: Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

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436-009-0040 Fee Schedule

(1) Fee Schedule Table.

(a) Unless otherwise provided by contract or fee discount agreement allowed by these rules, insurers must pay according to the following table:

Services	Codes	Payment Amount:	
Services billed with CPT ® codes, HCPCS codes, or Oregon Specific Codes (OSC):	Listed in Appendix B and performed in medical service provider’s office	Lesser of:	Amount in non-facility column in Appendix B, or
			Provider’s usual fee
	Listed in Appendix B and not performed in medical service provider’s office	Lesser of:	Amount in facility column in Appendix B*, or
			Provider’s usual fee
Dental Services billed with dental procedure codes:	D0000 through D9999	90% of provider’s usual fee	
Ambulance Services billed with HCPCS codes:	A0425, A0426, A0427, A0428, A0429, A0433, and A0434	100% of provider’s usual fee	
Services billed with HCPCS codes:	Not listed in the fee schedule	80% of provider’s usual fee	
Services not described above:		80% of provider’s usual fee	
* However, for all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the Non-Facility Maximum column.			

(b) The global period is listed in the column 'Global Days' of Appendix B.

(2) Anesthesia.

(a) When using the American Society of Anesthesiologists Relative Value Guide, a basic unit value is determined by reference to the appropriate anesthesia code. The total anesthesia value is made up of a basic unit value and, when applicable, time and modifying units.

(b) Physicians or certified nurse anesthetists may use basic unit values only when they personally administer the general anesthesia and remain in constant attendance during the procedure for the sole purpose of providing the general anesthesia.

(c) Attending surgeons may not add time units to the basic unit value when administering local or regional block for anesthesia during a procedure. The modifier 'NT' (no time) must be on the bill.

(d) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the payment for the surgical procedure.

(e) In calculating the units of time, use 15 minutes per unit. If a medical provider bills for a portion of 15 minutes, round the

time up to the next 15 minutes and pay one unit for the portion of time.

(f) The maximum allowable payment amount for anesthesia codes is determined by multiplying the anesthesia value by a conversion factor of \$60.93.

Unless otherwise provided by contract or fee discount agreement permitted by these rules, the insurer must pay the lesser of:

(A) The maximum allowable payment amount for anesthesia codes; or

(B) The provider's usual fee.

(g) When the anesthesia code is designated by IC (individual consideration), unless otherwise provided by a contract or fee discount agreement, the insurer must pay 80 percent of the provider's usual fee.

(h) Payment for services billed with modifiers QY, QK, or QX is at 50 percent of the applicable fee schedule amount.

(3) Surgery.

Unless otherwise provided by contract or fee discount agreement permitted by these rules, insurers must pay multiple surgical procedures performed in the same session according to the following:

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(a) One surgeon

Procedures	Appendix B lists:	The payment amount is:	
Principal procedure	A dollar amount	The lesser of:	The amount in Appendix B; or
			The billed amount
	80% of billed amount	80% of billed amount	
Any additional procedures* including: • diagnostic arthroscopy performed prior to open surgery • the second side of a bilateral procedure	A dollar amount	The lesser of:	50% of the amount in Appendix B; or
			The billed amount
	80% of billed amount	40% of the billed amount (unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 80% of the billed amount)	
*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.			

(b) Two or more surgeons

Procedures	Appendix B lists:	The payment amount for each surgeon is:	
Each surgeon performs a principal procedure (and any additional procedures) Any additional procedures including: <ul style="list-style-type: none">diagnostic arthroscopy performed prior to open surgerythe second side of a bilateral procedure	A dollar amount	The lesser of:	75% of the amount in Appendix B for the principal procedures (and 37.5% of the amount in Appendix B for any additional procedures*); or
			The billed amount
	80% of billed amount	60% of the billed amount (and 30% of the billed amount for any additional procedures*) (unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 60% of the billed amount)	
*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.			

(c) Assistant surgeons

Procedures	Appendix B lists:	The payment amount is:	
One or more surgical procedures	A dollar amount	The lesser of:	20% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	20% of the surgeon(s) fee calculated in subsections (a) or (b)	

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(d) Nurse practitioners or physician associates

Procedures	Appendix B lists:	The payment amount is:	
One or more surgical procedures as the primary surgical provider, billed without modifier "81."	A dollar amount	The lesser of:	85% of the surgeon(s) fee calculated in subsections (a) or (b); or
	80% of billed amount		The billed amount
One or more surgical procedures as the surgical assistant*	A dollar amount	The lesser of:	15% of the surgeon(s) fee calculated in subsections (a) or (b); or
	80% of billed amount		The billed amount
*Physician associates and nurse practitioners must mark their bills with a modifier "81." Chart notes must document when medical services have been provided by a physician associate or nurse practitioner.			

(e) Self-employed surgical assistants who work under the direct control and supervision of a physician

Procedures	Appendix B lists:	The payment amount is:	
One or more surgical procedures	A dollar amount	The lesser of:	10% of the surgeon(s) fee calculated in subsections (a) or (b); or
	80% of billed amount		The billed amount
			10% of the surgeon(s) fee calculated in subsections (a) or (b)

(f) When a surgeon performs surgery following severe trauma, and the surgeon does not think the fees should be reduced under the multiple surgery rule, the surgeon may request special consideration by the insurer. The surgeon must provide written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.

(g) If the surgery is nonelective, the physician is entitled to payment for the initial evaluation of the patient in addition to the global fee for the surgical procedure(s) performed. However, the pre-operative visit for elective surgery is included in the listed global value of the surgical procedure, even if the pre-operative visit is more than one day before surgery.

(4) Radiology Services.

(a) Insurers only have to pay for X-ray films of diagnostic quality that include a report of the findings. Insurers will not pay for 14" x 36" lateral views.

(b) When multiple contiguous areas are examined by computerized axial tomography (CAT) scan, computerized tomography angiography (CTA), magnetic resonance

angiography (MRA), or magnetic resonance imaging (MRI), then the technical component must be paid 100 percent for the first area examined and 75 percent for all subsequent areas. These reductions do not apply to the professional component.

The reductions apply to multiple studies done within two days, unless the ordering provider provides a reasonable explanation of why the studies needed to be done on separate days.

(5) Pathology and Laboratory Services.

(a) The payment amounts in Appendix B apply only when there is direct physician involvement.

(b) Laboratory fees must be billed in accordance with ORS 676.310. If a physician submits a bill for laboratory services that were performed in an independent laboratory, the bill must show the amount charged by the laboratory and any service fee that the physician charges.

(6) Physical Medicine and Rehabilitation Services.

(a) Time-based CPT® codes must be billed and paid per code according to this table:

Treatment Time Per Code	Bill and Pay As
0 to 7 minutes	0
8 to 22 minutes	1 unit
23 to 37 minutes	2 units
38 to 52 minutes	3 units
53 to 67 minutes	4 units
68 to 82 minutes	5 units

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(b) Except for CPT® codes 97161, 97162, 97163, 97164, 97165, 97166, 97167, or 97168, payment for modalities and therapeutic procedures is limited to a total of three separate CPT®-coded services per day for each provider, identified by their federal tax ID number. An additional unit of time for the same CPT® code does not count as a separate code. When a provider bills for more than three separate CPT®-coded services per day, the insurer is required to pay the codes that result in the highest payment to the provider.

(c) For all time-based modalities and therapeutic procedures that require constant attendance, the chart notes must clearly indicate the time each modality or procedure begins and the time each modality or procedure ends or the amount of time spent providing each modality or procedure.

(d) CPT® codes 97010 through 97028 are not payable unless they are performed in conjunction with other procedures or modalities that require constant attendance or knowledge and skill of the licensed medical provider.

(e) When multiple treatments are provided simultaneously by one machine, device, or table there must be a notation on the bill that treatments were provided simultaneously by one machine, device, or table and there must be only one charge.

(7) Reports.

(a) Except as otherwise provided in OAR 436-009-0060, when another medical provider, or an insurer or its representative asks a medical provider to prepare a report, or review records or reports, the medical provider should bill the insurer for their report or review of the records using CPT® codes such as

99080. The bill should include documentation of time spent reviewing the records or reports.

(b) If the insurer asks the medical service provider to review the IME report and respond, the medical service provider must bill for the time spent reviewing and responding using OSC D0019. The bill should include documentation of time spent.

(8) Nurse Practitioners and Physician Associates.

Services provided by authorized nurse practitioners, physician associates, or out-of-state nurse practitioners must be paid at 85 percent of the amount calculated in section (1) of this rule.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Amended 12/9/25 as Admin. Order 24-055, eff. 1/1/25 Temp
Amended 3/11/25 as Admin. Order 24-050, eff. 4/1/25

436-009-0060 Oregon Specific Codes

(1) Multidisciplinary Services.

(a) Services provided by multidisciplinary programs not otherwise described by CPT® codes must be billed under Oregon specific codes.

(b) Bills using the multidisciplinary codes must include copies of the treatment record that specifies:

(A) The type of service rendered,

(B) The medical provider who provided the service,

(C) Whether treatment was individualized or provided in a group session, and

(D) The amount of time treatment was rendered for each service billed.

(2) Table of all Oregon Specific Codes (For OSC fees, [see Appendix B.](#))

Service	OSC
Addictionologist consultant services: Services requested by a managed care organization consisting of an extensive records review, a physical exam, reports, responses to letters, and urine drug screening.	D0091
Arbiter exam - level 1: A basic medical exam with no complicating factors.	AR001
Arbiter exam - level 2: A moderately complex exam that may have complicating factors.	AR002
Arbiter exam - level 3: A very complex exam that may have several complicating factors.	AR003
Arbiter exam - level 4: A very complex exam that may have several complicating factors or multiple body systems.	AR004
Arbiter exam – limited: A limited exam that may involve a newly accepted condition, or a partial exam.	AR005
Arbiter exam – psychiatric and neuropsychological exam: First hour of the examination.	AR006
Arbiter exam – psychiatric and neuropsychological exam: Each additional 30 minutes of the examination. If an arbiter bills for a portion of 30 minutes, the insurer must round the time up to the next 30 minutes and pay one unit for the portion of time.	AR007
Arbiter file review - level 1: A file review of a limited record.	AR021
Arbiter file review - level 2: A file review of an average record.	AR022

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Service	OSC
Arbiter file review - level 3: A file review of a large record or a disability evaluation without an exam.	AR023
Arbiter file review - level 4: A file review of an extensive record.	AR024
Arbiter file review - level 5: A file review of an extensive record with unique factors.	AR025
Arbiter report - level 1: A report that answers standard questions.	AR011
Arbiter report - level 2: A report that answers standard questions and complicating factors.	AR012
Arbiter report - level 3: A report that answers standard questions and multiple complicating factors.	AR013
Arbiter report - level 4: A report that answers complex questions and addresses several complicating factors or multiple body systems.	AR014
Arbiter report - complex supplemental report: A report to clarify information or to address additional issues.	AR032
Arbiter report - limited supplemental report: A report to clarify information or to address additional issues.	AR031
Closing exam: An exam to measure impairment after the worker's condition is medically stationary.	CE001
Closing report: A report that captures the findings of the closing exam.	CR001
Consultation – attorney: Time spent consulting with an insurer's attorney, including time spent reviewing records.	D0001
Consultation – insurer: Time spent consulting with an insurer, including time spent reviewing records.	D0030
Copies of medical records: Copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0001
Copies of medical records electronically: Electronic copies of medical records provided on a disc or USB drive, uploaded to an insurer's secure website, or using secure email or e-fax, requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0002
Deposition time: Time spent being deposed by insurer's attorney, includes time for preparation, travel, and deposition.	D0002
Director required medical exam: Services by a physician selected under ORS 656.327 to perform reasonable and appropriate tests, or examine the worker. Services must be paid at an hourly rate for exam (P0001) and record review (P0002) up to six hours combined.	P0001
Director required file review time: Time spent by a physician selected under ORS 656.327 to review the record. Services must be paid at an hourly rate for record review (P0002) and exam (P0001) up to six hours combined.	P0002
Director required medical report: Preparation and submission of the report.	P0003
Director required review - complex case fee: One time, flat fee pre-authorized by the director for an extensive review in a complex case.	P0004
Ergonomic consultation - 1 hour (includes travel): Must be preauthorized by insurer. Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications.	97661
IME (independent medical exam): Report, addendum to a report, file review, or exam.	D0003

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Service	OSC
IME – review and response: Insurer-requested review and response by treating physician; document time spent.	D0019
Interdisciplinary rehabilitation conference - 10 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97655
Interdisciplinary rehabilitation conferences – intermediate - 20 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97656
Interdisciplinary rehabilitation conferences – complex - 30 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97657
Interdisciplinary rehabilitation conferences – complex - each additional 15 minutes - up to 1 hour maximum: Each additional 15 minutes complex conference - up to 1 hour maximum.	97658
Interpreter mileage	D0041
Interpreter services – provided by a noncertified interpreter or nonqualified, excluding American Sign Language	D0004
Interpreter services – American Sign Language	D0005
Interpreter services - provided by a health care interpreter certified or qualified by the Oregon Health Authority, excluding American Sign Language	D0006
Interpreter Services – provided by a health care interpreter certified or qualified by the Oregon Health Authority and employed by a medical provider solely to provide interpreter services	D0007
Job site visit - 1 hour (includes travel): Must be preauthorized by insurer. A work site visit to identify characteristics and physical demands of specific jobs.	97659
Job site visit - each additional 30 minutes	97660
Multidisciplinary conference – initial - up to 30 minutes	97670
Multidisciplinary conference - initial/complex - up to 60 minutes	97671
Narrative – brief: Narrative by the attending physician or authorized nurse practitioner, including a summary of treatment to date and current status and, if requested, brief answers to one to five questions related to the current or proposed treatment.	N0001
Narrative – complex: Narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, treatment to date, current status, impairment, prognosis, and medically stationary information.	N0002
Nursing evaluation - 30 minutes: Nursing assessment of medical status and needs in relationship to rehabilitation.	97664
Nursing evaluation - each additional 15 minutes	97665
Nutrition evaluation - 30 minutes: Evaluation of eating habits, weight, and required modifications in relationship to rehabilitation.	97666
Nutrition evaluation - each additional 15 minutes	97667
PCE (physical capacity evaluation) - first level: This is a limited evaluation primarily to measure musculoskeletal components of a specific body part. These components include such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level generally requires 30 to 45 minutes of actual patient contact. A first level PCE is paid under OSC 99196, which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99196

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Service	OSC
PCE - second level: This is a PCE to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish residual functional capacities for claim closure. This level generally requires not less than two hours of actual patient contact. The second level PCE is paid under OSC 99197, which includes the evaluation and report. Additional 15 minute increments may be added to measure additional body parts, to establish endurance and to project tolerances. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99197
PCE – each additional 15 minutes	99193
Physical conditioning - group - 1 hour: Conditioning exercises and activities, graded and progressive.	97642
Physical conditioning - group - each additional 30 minutes	97643
Physical conditioning – individual - 1 hour: Conditioning exercises and activities, graded and progressive.	97644
Physical conditioning – individual - each additional 30 minutes	97645
Professional case management – individual 15 minutes: Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician).	97654
Records review: Review of medical records on an MCO-enrolled claim by a nontreating physician requested by an insurer or a managed care organization.	RECRW
Social worker evaluation - 30 minutes: Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome.	97668
Social worker evaluation – each additional 15 minutes	97669
Therapeutic education – individual 30 minutes Medical, psychosocial, nutritional, and vocational education dependent on needs and stated goals.	97650
Therapeutic education – individual - each additional 15 minutes	97651
Therapeutic education - group 30 minutes: Medical, psychosocial, nutritional, and vocational education dependent on needs and stated goals.	97652
Therapeutic education - group - each additional 15 minutes	97653
Video Review: Review of video requested by an insurer or a managed care organization.	VIDEO
Vocational evaluation - 30 minutes: Evaluation of work history, education, and transferable skills coupled with physical limitations in relationship to return-to-work options.	97662
Vocational evaluation - each additional 15 minutes	97663
WCE (work capacity evaluation): This is a residual functional capacity evaluation that generally requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. A WCE is paid under OSC 99198, which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report. Special emphasis should be given to: <ul style="list-style-type: none"> • The ability to perform essential physical functions of the job based on a specific job; • Analysis as related to the accepted condition; • The ability to sustain activity over time; and • The reliability of the evaluation findings. 	99198
WCE – each additional 15 minutes	99193
Work simulation - group 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97646
Work simulation - group - each additional 30 minutes	97647

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Service	OSC
Work simulation - individual 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97648
Work simulation - individual - each additional 30 minutes	97649
WRME (worker requested medical exam): Exam, report, or time spent reviewing the records associated with the scheduled exam.	W0001

(3) CARF / JCAHO Accredited Programs.

(a) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program will not be paid unless the program is accredited for that purpose by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

(b) Organizations that have applied for CARF accreditation, but have not yet received accreditation, may receive payment for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. The organizations may provide multidisciplinary services under this section for a period of up to six months from the date CARF provided notice to the organization that the accreditation process has been initiated, or until such time as CARF accreditation has been received or denied, whichever occurs first.

(c) Notwithstanding OAR 436-009-0010(4)(a), program fees for services within a multidisciplinary program may be used based upon written pre-authorization from the insurer. Programs must identify the extent, frequency, and duration of services to be provided.

(d) All job site visits and ergonomic consultations must be preauthorized by the insurer.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Amended 3/9/23 as Admin. Order 23-050, eff. 4/1/23
Amended 3/5/24 as Admin. Order 24-050, eff. 4/1/24
Amended 3/11/25 as Admin. Order 24-050, eff. 4/1/25

436-009-0080 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

(1) **Durable medical equipment (DME)**, such as Transcutaneous Electrical Nerve Stimulation (TENS), Microcurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc., is equipment that:

- (a) Is primarily and customarily used to serve a medical purpose,
- (b) Can withstand repeated use,

- (c) Could normally be rented and used by successive patients,
- (d) Is appropriate for use in the home, and
- (e) Is not generally useful to a person in the absence of an illness or injury.

(2) A **prosthetic** is an artificial substitute for a missing body part or any device aiding performance of a natural function. Examples: hearing aids, eye glasses, crutches, wheelchairs, scooters, artificial limbs, etc.

The insurer must pay for the repair or replacement of prosthetic appliances damaged as a result of a compensable injury, even if the worker received no other injury. If the appliance is not repairable, the insurer must replace the appliance with a new appliance comparable to the one damaged.

If the worker chooses to upgrade the prescribed prosthetic appliance, the worker may do so but must pay the difference in price.

(3) An **orthotic** is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of a moveable body part. Examples: brace, splint, shoe insert or modification, etc.

(4) **Supplies** are materials that may be reused multiple times by the same person, but a single supply is not intended to be used by more than one person, including, but not limited to incontinent pads, catheters, bandages, elastic stockings, irrigating kits, sheets, and bags.

(5) When billing for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), providers must use the following modifiers, when applicable:

- (a) NU for purchased, new equipment;
- (b) UE for purchased, used equipment; and
- (c) RR for rented equipment

(6) Unless otherwise provided by contract or sections (7) through (11) of this rule, insurers must pay for DMEPOS according to the following table:

If DMEPOS is:	And HCPCS is:	Then payment amount is:	
New	Listed in Appendix E	The lesser of	Amount in Appendix E; or Provider's usual fee
	Not listed in Appendix E	80% of provider's usual fee	
Used	Listed in Appendix E	The lesser of	75% of amount in Appendix E; or

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			Provider's usual fee
	Not listed in Appendix E	80% of provider's usual fee	
Rented (monthly rate)	Listed in Appendix E	The lesser of	10% of amount in Appendix E; or
			Provider's usual fee
	Not listed in Appendix E	80% of provider's usual fee	

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(7) Unless a contract establishes a different rate, the table below lists maximum monthly rental rates for the codes listed (do not use Appendix E or section (6) to determine the rental rates for these codes):

Code	Monthly Rate	Code	Monthly Rate
E0163	\$26.33	E0849	\$98.40
E0165	\$30.24	E0900	\$93.68
E0168	\$27.28	E0935	\$996.97
E0261	\$259.66	E0940	\$52.20
E0277	\$1135.64	E0990	\$25.52
E0441	\$86.85	E1800	\$262.29
E0650	\$1423.50	E1815	\$276.15
		E2402	\$2487.86

(8) For items rented, unless otherwise provided by contract:

(a) The maximum daily rental rate is one thirtieth (1/30) of the monthly rate established in sections (6) and (7) of this rule.

(b) After a rental period of 13 months, the item is considered purchased, if the insurer so chooses.

(c) The insurer may purchase a rental item anytime within the 13-month rental period, with 75 percent of the rental amount paid applied towards the purchase.

(9) For items purchased, unless otherwise provided by contract, the insurer must pay for labor and reasonable expenses at the provider's usual rate for:

(a) Any labor and reasonable expenses directly related to any repairs or modifications subsequent to the initial set-up; or

(b) The provider may offer a service agreement at an additional cost.

(10) **Hearing aids** Notwithstanding OAR 436-009-0010(1)(a), a licensed audiologist may prescribe programmable behind the ear (BTE), in the ear (ITE), and completely in the canal (CIC) multichannel hearing aids without the approval of an attending physician, authorized nurse practitioner, or specialist physician. Testing must be done by a licensed audiologist or an otolaryngologist.

Any hearing aids other than BTEs, ITEs, or CICs needed for medical conditions will be considered based on justification from the attending physician or authorized nurse practitioner.

Unless otherwise provided by contract, insurers must pay the provider's usual fee for **hearing services** billed with HCPCS codes V5000 through V5999. However, without approval from the insurer or director, the payment for hearing aids may not exceed \$7000 for a pair of hearing aids, or \$3500 for a single hearing aid.

If the worker chooses to upgrade the prescribed hearing aid, the worker may do so but must pay the difference in price.

(11) Unless otherwise provided by contract, insurers must pay the provider's usual fee for **vision services** billed with HCPCS codes V0000 through V2999.

(12) The worker may select the service provider. For claims enrolled in a managed care organization (MCO) the worker may be required to select a provider from a list specified by the MCO.

(13) Except as provided in section (10) of this rule, the payment amounts established by this rule do not apply to a worker's direct purchase of DMEPOS. Workers are entitled to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.

(14) DMEPOS dispensed by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Amended 12/9/25 as Admin. Order 24-055, eff. 1/1/25 Temp
Amended 3/11/25 as Admin. Order 24-050, eff. 4/1/25

436-009-0090 Pharmaceutical

(1) General.

(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the patient is medically stationary.

(b) When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. However, a patient may insist on receiving the brand-name drug and either pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy.

(c) Unless otherwise provided by MCO contract, the patient may select the pharmacy.

(2) Pharmaceutical Billing and Payment.

(a) Pharmaceutical billings must contain the National Drug Code (NDC) to identify the drug or biological billed. This includes compounded drugs, which must be billed by ingredient, listing each ingredient's NDC. Ingredients without an NDC are not reimbursable.

(b) All bills from pharmacies must include the prescribing provider's NPI or license number.

(c) Unless otherwise provided by contract, insurers must pay medical providers for prescription medication, including

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injectable drugs, at the medical provider's usual fee, or the maximum allowable fee, whichever is less. However, drugs provided by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

(d) Unless directly purchased by the worker (see OAR 436-009-0025(5)), the maximum allowable fee for pharmaceuticals is calculated according to the following table:

If the drug dispensed is:	Then the maximum allowable fee is:
A generic drug	83.5 % of the dispensed drug's AWP plus a \$2.00 dispensing fee
A brand name drug without a generic equivalent or the prescribing provider has specified that the drug may not be substituted with a generic equivalent	83.5 % of the dispensed drug's AWP plus a \$2.00 dispensing fee
A brand name drug with a generic equivalent and the prescribing provider has not prohibited substitution	83.5 % of the average AWP for the class of generic drugs plus a \$2.00 dispensing fee
A compound drug	83.5 % of the AWP for each individual ingredient plus a single compounding fee of \$10.00 (The compounding fee includes the dispensing fee.)

(Note: "AWP" means the Average Wholesale Price effective on the date the drug was dispensed.)

(e) Insurers must use a nationally published prescription pricing guide for calculating payments to the provider, e.g., RED BOOK or Medi-Span.

(3) Dispensing by Medical Service Providers.

(a) Except in an emergency, prescription drugs for oral consumption dispensed by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the patient, up to a maximum of 10 days.

(b) For dispensed over-the-counter medications, the insurer must pay the retail-based fee.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.248, 656.252, 656.254

Hist: Amended 3/9/23 as Admin. Order 23-050, eff. 4/1/23

436-009-0110 Interpreters

(1) Choosing an Interpreter.

(a) A worker may choose a person to communicate with a medical provider when the worker and the medical provider speak different languages, including sign language. The worker may choose a family member, a friend, an employee of the medical provider, or an interpreter. However, for signed language interpretation services, the worker may only choose an interpreter who is a medical sign language interpreter licensed under ORS 676.765. A representative of the worker's employer may not provide interpreter services. The medical provider may disapprove of the worker's choice at any time the medical provider feels the interpreter services are not improving communication with the worker, or feels the interpretation is not complete or accurate.

(b) When a worker asks an insurer to arrange for interpreter services, the insurer must:

(A) For interpretation services, other than signed language interpretation services, use a certified or qualified health care

interpreter listed on the Oregon Health Care Interpreter Registry of the Oregon Health Authority available at:

<http://www.oregon.gov/OHA/OEI/Pages/HCI-Program.aspx>.

The interpreter's certification or qualification must be in effect on the date the interpreter services are provided. If no certified or qualified health care interpreter is available, the insurer may schedule an interpreter of its choice subject to the limits in subsection (a) of this section.

(B) For signed language interpretation services, use a sign language interpreter licensed under ORS 676.750 to 676.789.

(c) Prior to offering interpreter services by a health care interpreter employed by the medical provider, the medical provider must inform the worker of the worker's right to choose an interpreter.

(2) Billing.

(a) Interpreters must charge the usual fee they charge to the general public for the same service.

(b) Interpreters may only bill an insurer or, if provided by contract, a managed care organization (MCO). However, if the insurer denies the claim, interpreters may bill the worker.

(c) Interpreters may bill for interpreter services and for mileage when the round-trip mileage is 15 or more miles. For the purpose of this rule, "mileage" means the number of miles traveling from the interpreter's starting point to the exam or treatment location and back to the interpreter's starting point.

(d) If the interpreter arrives at the provider's office for an appointment that was required by the insurer or the director, e.g., an independent medical exam, a physician review exam, or an arbiter exam, the interpreter may bill for interpreter services and mileage according to section (2)(c) of this rule even if:

(A) The worker fails to attend the appointment; or

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(B) The provider has to cancel or reschedule the appointment.

(e) If interpreters do not know the workers' compensation insurer responsible for the claim, they may contact the division at 503-947-7814. They may also access insurance policy information at

<http://www4.cbs.state.or.us/ex/wcd/cov/index.cfm>.

(3) Billing and Payment Limitations.

(a) When an appointment was not required by the insurer or director, interpreters may not bill any amount for interpreter services or mileage if the provider cancels or reschedules the appointment.

(b) Other than missed appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams, an interpreter may bill a workers' compensation client if the client fails to attend the appointment and if:

(A) The interpreter has a written missed-appointment policy that applies not only to workers' compensation clients, but to all clients;

(B) The interpreter routinely notifies all clients of the missed-appointment policy;

(C) The interpreter's written missed-appointment policy shows the cost to the client; and

(D) The client has signed the missed-appointment policy.

(c) The implementation and enforcement of subsection (b) of this section is a matter between the interpreter and the client. The division is not responsible for the implementation or enforcement of the interpreter's policy.

(d) The insurer is not required to pay for interpreter services or mileage when the services are provided by:

(A) A family member or friend of the worker; or

(B) A medical provider's employee, unless the employee is a health care interpreter certified or qualified by the Oregon Health Authority and is employed by the provider solely to provide in-person (face-to-face) interpreter services.

(e) A health care interpreter certified or qualified by the Oregon Health Authority who is employed by a medical provider solely to provide in-person (face-to-face) interpreter services is not entitled to mileage reimbursement.

(4) Billing Timelines.

(a) Interpreters must bill within:

(A) 60 days of the date of service;

(B) 60 days after the interpreter has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or

(C) 60 days after any litigation affecting the compensability of the service is final, if the interpreter receives written notice of the final litigation from the insurer.

(b) If the interpreter bills past the timelines outlined in subsection (a) of this section, the interpreter may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.

(c) When submitting a bill later than outlined in subsection (a) of this section, an interpreter must establish good cause.

(d) A bill is considered sent by the date the envelope is post-marked or the date the document is faxed.

(5) Billing Form.

(a) Interpreters must use an invoice when billing for interpreter services and mileage and use Oregon specific code:

(A) D0004 for interpreter services, excluding American Sign Language interpreter services, provided by noncertified interpreters;

(B) D0005 for American Sign Language interpreter services;

(C) D0006 for interpreter services, excluding American Sign Language interpreter services, provided by a health care interpreter certified or qualified by the Oregon Health Authority;

(D) D0007 for interpreter services provided by a health care interpreter certified or qualified by the Oregon Health Authority and employed by the provider solely to provide in-person (face-to-face) interpreter services; and

(E) D0041 for mileage.

(b) An interpreter's invoice must include:

(A) The interpreter's name, the interpreter's company name, if applicable, billing address, and phone number;

(B) The worker's name;

(C) The worker's workers' compensation claim number, if known;

(D) The correct Oregon specific codes for the billed services (D0004, D0005, D0006, D0007, or D0041);

(E) The workers' compensation insurer's name and address;

(F) The date interpreter services were provided;

(G) The name and address of the medical provider that conducted the exam or provided treatment;

(H) The total amount of time interpreter services were provided; and

(I) The mileage, if the round trip was 15 or more miles.

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(6) Payment Calculations.

(a) Unless otherwise provided by contract, insurers must pay the lesser of the maximum allowable payment amount or the interpreter's usual fee.

(b) Insurers must use the following table to calculate the maximum allowable payment for interpreters:

For:	The maximum payment is:
Interpreter services provided by a noncertified or nonqualified interpreter of an hour or less	\$75.00
In person (face to face) interpreter services of two hours or less provided by health care interpreters certified or qualified by the Oregon Health Authority ¹ who are not employed by the health care provider	\$174.00
Interpreter services via video or audio of one hour or less provided by health care interpreters certified or qualified by the Oregon Health Authority ¹	\$87.00
In-person (face to face) American sign language interpreter services of two hours or less	\$174.00
American sign language interpreter services via video or audio of one hour or less	\$87.00
Interpreter services provided by a noncertified or nonqualified interpreter of more than one hour	\$18.75 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
In-person interpreter service of more than two hours or, if provided via video or audio, of more than one hour provided by health care interpreters certified or qualified by the Oregon Health Authority ¹	\$21.75 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
In-person American sign language interpreter services of more than two hours or, if provided by video or audio, of more than one hour	\$21.75 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
In-person (face to face) interpreter services of 15 minutes or more provided by health care interpreters certified or qualified by the Oregon Health Authority ¹ employed by a medical provider solely to provide interpreter services	\$21.75 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
Mileage of less than 15 miles round trip	No payment allowed
Mileage of 15 or more miles round trip	The private vehicle mileage rate published in Bulletin 112
An examination required by the director or insurer that the worker fails to attend or when the provider cancels or reschedules qualified by the Oregon Health Authority ¹ employed by a medical provider solely to provide interpreter services	\$75.00 no-show fee plus payment for mileage if 15 or more miles round trip
An interpreter who is the only person in Oregon able to interpret a specific language	The amount billed for interpreter services and mileage
¹ A list of certified health care interpreters can be found online under the Health Care Interpreter Registry at http://www.oregon.gov/oha/oei/Pages/HCI-Program.aspx .	

(7) Payment Requirements.

(a) When the medical exam or treatment is for an accepted claim or condition, the insurer must pay for interpreter services and mileage if the round-trip mileage is 15 or more miles.

(b) When the worker fails to attend or the provider cancels or reschedules a medical exam required by the director or the

insurer, the insurer must pay the no-show fee and mileage if the round-trip mileage is 15 or more miles.

(c) The insurer must retain the invoice and pay the interpreter within:

(A) 14 days of the date of claim acceptance or any action causing the service to be payable, which includes receiving a

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bill for or chart note of the corresponding medical appointment, or 45 days of receiving the invoice, whichever is later; or

(B) 45 days of receiving the invoice for an exam required by the insurer or director.

(d) When an interpreter bills within 12 months of the date of service, the insurer may not reduce payment due to late billing.

(e) When an interpreter bills over 12 months after the date of service, the bill is not payable, except when a provision of subsection (4)(c) of this rule is the reason the billing was submitted after 12 months.

(f) If the insurer does not receive all the information to process the invoice, other than a bill for or chart note of the corresponding medical appointment, the insurer must return the invoice to the interpreter within 20 days of receipt. The insurer must provide specific information about what is needed to process the invoice.

(g) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for nonpayment or reduction of each service billed.

(h) The insurer must provide a written explanation of benefits for services paid or denied and must send the explanation to the interpreter that billed for the services. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. All the information on the written explanation must be in 10 point size font or larger.

(i) Electronic and written explanations must include:

(A) The payment amount for each service billed. When the payment covers multiple workers, the explanation must clearly separate and identify payments for each worker;

(B) The specific reason for nonpayment, reduced payment, or discounted payment for each service billed;

(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to an interpreter's payment questions within two days, excluding Saturdays, Sundays, and legal holidays;

(D) The following notice, Web link, and phone number:

"To access the information about Oregon's Medical Fee and Payment rules, visit www.oregonwcdoc.info or call 503-947-7606";

(E) Space for a signature and date; and

(F) A notice of the right to administrative review in bold text and formatted as follows:

If you disagree with this decision about payment, contact {the insurer or its representative} first. If you still disagree about payment, you may request administrative review by the Department of Consumer and Business Services (DCBS). To request review, you must do all of the following:

- **Submit your request within 90 days of the mailing date of this explanation**

- **Sign and date this explanation in the space provided**
- **Explain why you think the payment is incorrect**
- **Attach required supporting documentation of your expense**
- **Send the documents to:**

**DCBS Workers' Compensation Division
Medical Resolution Team**

350 Winter Street NE

PO Box 14480

Salem OR 97309-0405

Or

**Fax your request to the Medical Resolution
Team at 503-947-7629**

- **Send a copy of your request to the insurer**

Keep a copy of this document for your records.

(j) The insurer or its representative must respond to an interpreter's inquiry about payment within two days, excluding Saturdays, Sundays, and legal holidays. The insurer or its representative may not refer the interpreter to another entity to obtain the answer.

(k) The insurer or its representative and an interpreter may agree to send and receive payment information by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Information Protection Act under ORS 646A.600 to 646A.628 and federal law.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248

Hist: Amended 11/22/23 as Admin. Order 23-054, eff. 1/1/2024

Amended 3/5/24 as Admin. Order 24-050, eff. 4/1/24

Amended 3/11/25 as Admin. Order 24-050, eff. 4/1/25

436-009-0998 Sanctions and Civil Penalties

(1) The director may impose sanctions upon a medical provider or insurer for violation of these rules in accordance with OAR 436-010-0340.

(2) If an insurer applies a contract or fee discount agreement to a provider's bill that is incorrect, the insurer must pay the provider's bill at the provider's usual fee or according to the fee schedule, whichever is less, and the insurer may be subject to a civil penalty.

(3) Although insurers may contract with provider networks for certain services, the insurer is responsible for their own actions as well as the actions of others acting on the insurer's behalf. If an insurer or someone acting on the insurer's behalf violates any provision of these rules, the director may impose a civil penalty against the insurer.

(4) If the director finds a pattern and practice, or an egregious violation of applying incorrect discounts to providers' fees under these rules, by an insurer or someone acting on the

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insurer's behalf, the director may issue a civil penalty up to the amount allowed under ORS chapter 656.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.254, 656.745

Hist: Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

Appendix A - Matrix for health care provider types*

See OAR 436-009-0005 and 436-010-0210

	Attending physician status (primarily responsible for treatment of a patient)	Provides compensable medical services for initial injury or illness	Authorizes payment of temporary disability and releases the patient to work	Establishes impairment findings (permanent disability)	Provides compensable medical services for aggravation of injury or illness
Type A attending physician Medical doctor Doctor of osteopathic medicine Oral and maxillofacial surgeon Podiatric physician and surgeon	Yes	Yes	Yes	Yes	Yes
Type B attending physician Chiropractic physician Naturopathic physician	Yes, for a total of 60 consecutive days or 18 visits, from the date of the first visit on the initial claim with any Type B attending physician.	Yes, unless the total of 60 consecutive days or 18 visits from the date of the first visit on the initial claim with any Type B attending physician has passed. Or, if authorized by an attending physician and under a treatment plan.	Yes, 30 days from the date of the first visit with any type B attending physician on the initial claim, if within the specified 18 visit period.	No, unless the type B attending physician is a chiropractic physician.	No, unless authorized by a type A attending physician and under a written treatment plan.
Type C attending physician Physician Associate	Yes, for a total of 180 consecutive days from the date of the first visit on the initial claim with any physician associate.	Yes, for 180 consecutive days from the date of the first visit to any physician associate on the initial claim. Or, if authorized by an attending physician.	Yes, for 180 days from the date of the first visit with any physician associate on the initial claim.	No.	No, unless authorized by a type A attending physician.
Authorized nurse practitioner	No	Yes, for 180 consecutive days from the date of the first visit to any authorized nurse practitioner on the initial claim. Or, if authorized by attending physician.	Yes, for 180 days from the date of the first visit with any authorized nurse practitioner on the initial claim.	No	No, unless authorized by a type A attending physician.
Emergency room physician	No, if the physician refers the patient to a primary care physician.	Yes	An ER physician who is not authorized to serve as attending physician under ORS 656.005(12)(c) may authorize temporary disability for up to 14 days, including retroactive authorization.	No, if patient referred to a primary care physician.	Yes
"Other Health Care Providers" (e.g. acupuncturist)	No	Yes, for 30 consecutive days or 12 visits from the date of the first visit on the initial claim with any "Other Health Care Providers." Thereafter, services must be provided under a treatment plan and authorized by the attending physician.	No	No	No, unless referred by a type A attending physician and under a written treatment plan.

* This matrix does not apply to Managed Care Organizations

Appendices B through E

Oregon Workers' Compensation Maximum Allowable Payment Amounts

The Workers' Compensation Division no longer adopts the Federal Register that publishes Centers for Medicare and Medicaid Services' (CMS) relative value units (RVUs). The division publishes the following Appendices to the division 009 of chapter 436.

Appendix B (physician fee schedule) containing the maximum allowable payment amounts for services provided by medical service providers.

[Effective January 1, 2025]

Appendix C (ambulatory surgery center fee schedule amounts for surgical procedures), containing the maximum allowable payment amounts for surgical procedures including packaged procedures.

[Effective January 1, 2025]

Appendix D (ambulatory surgery center fee schedule amounts for ancillary services) containing the maximum allowable payment amounts for ancillary services integral to the surgical procedure.

[Effective January 1, 2025]

Appendix E (durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)) containing the maximum allowable payment amounts for durable medical equipment, prosthetics, orthotics, and supplies. [Effective January 1, 2025]

Note: If the above links do not connect you to the division's website, click:

<https://wcd.oregon.gov/medical/Pages/disclaimer.aspx>

If you have questions, call the Workers' Compensation Division, 503-947-7606.

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Link to the Maximum Allowable Payment Tables: <https://wcd.oregon.gov/medical/Pages/disclaimer.aspx>

Or, contact the division for a paper copy, 971-286-0316

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 010

MEDICAL SERVICES

Effective April 1, 2025

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436-010-0001 Purpose and Applicability of These Rules

(1) Purpose.

The purpose of these rules is to establish uniform standards for administering the delivery of and payment for medical services to workers within the workers' compensation system.

(2) Applicability of Rules.

(a) These rules apply on or after the effective date to carry out the provisions of ORS 656.245, 656.247, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794, and govern all providers of medical services licensed or authorized to provide a product or service under ORS chapter 656.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(c) Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, 656.794

Hist: Amended 3/3/21 as Admin. Order 21-052, eff. 4/1/21

436-010-0005 Definitions

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made part of these rules.

(2) **"Administrative review"** means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001.

(3) **"Attending physician"** has the same meaning as described in ORS 656.005(12)(b). See Appendix A "Matrix for Health Care Provider Types."

(4) **"Authorized nurse practitioner"** means a nurse practitioner licensed under ORS 678.375 to 678.390 who has certified to the director that the nurse practitioner has reviewed informational materials about the workers' compensation system provided by the director and who has been assigned an authorized nurse practitioner number by the director.

(5) **"Board"** means the Workers' Compensation Board and includes its Hearings Division.

(6) **"Chart note"** means a notation made in chronological order in a medical record in which the medical service provider records information such as subjective and objective findings, diagnosis, treatment rendered, treatment objectives, and return-to-work goals and status.

(7) **"Come-along provider"** means a primary care physician, chiropractic physician, physician associate, or an authorized nurse practitioner who is not a managed care organization (MCO) panel provider and who is authorized to continue to treat the worker when the worker becomes enrolled in an MCO. (See OAR 436-015-0070.)

(8) **"Date stamp"** means to stamp or display the initial receipt date and the recipient's name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.

(9) **"Days"** means calendar days.

(10) **"Direct control and supervision"** means the physician is on the same premises, at the same time, as the person providing

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a medical service ordered by the physician. The physician can modify, terminate, extend, or take over the medical service at any time.

(11) **“Direct medical sequela”** means a condition that is clearly established medically and originates or stems from an accepted condition. For example: The accepted condition is low back strain with herniated disc at L4-5. The worker develops permanent weakness in the leg and foot due to the accepted condition. The weakness is considered a “direct medical sequela.”

(12) **“Director”** means the director of the Department of Consumer and Business Services or the director’s designee.

(13) **“Division”** means the Workers’ Compensation Division of the Department of Consumer and Business Services.

(14) **“Eligible worker”** means a worker who has filed a claim or who has an accepted claim and whose employer is located in an MCO’s authorized geographical service area, covered by an insurer that has a contract with that MCO.

(15) **“Enrolled”** means an eligible worker has received notification from the insurer that the worker is being required to treat under the provisions of a managed care organization (MCO). However, a worker may not be enrolled who would otherwise be subject to an MCO contract if the worker’s primary residence is more than 100 miles outside the managed care organization’s certified geographical service area.

(16) **“Health care practitioner or health care provider”** has the same meaning as a “medical service provider.”

(17) **“Home health care”** means necessary medical and medically related services provided in the patient’s home environment. These services may include, but are not limited to, nursing care, medication administration, personal hygiene, or assistance with mobility and transportation.

(18) **“Hospital”** means an institution licensed by the State of Oregon as a hospital.

(19) **“Initial claim”** means the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared to be medically stationary by an attending physician or authorized nurse practitioner. For nondisabling claims, the “initial claim” means the first period of medical treatment immediately following the original filing of the occupational injury or disease claim ending when the attending physician or authorized nurse practitioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

(20) **“Insurer”** means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers’ compensation insurance in the state; or, an employer or employer group that has been certified under ORS 656.430 that meets the qualifications of a self-insured employer under ORS 656.407.

(21) **“Interim medical benefits”** means those services provided under ORS 656.247 on initial claims with dates of

injury on or after January 1, 2002 that are not denied within 14 days of the employer’s notice of the claim.

(22) **“Mailed or mailing date”** means the date a document is postmarked. Requests submitted by facsimile or “fax” are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped by the division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

(23) **“Managed care organization” or “MCO”** means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

(24) **“Medical evidence”** includes, but is not limited to: expert written testimony; written statements; written opinions, sworn affidavits, and testimony of medical professionals; records, reports, documents, laboratory, X-ray and test results authored, produced, generated, or verified by medical professionals; and medical research and reference material used, produced, or verified by medical professionals who are physicians or medical record reviewers in the particular case under consideration.

(25) **“Medical provider”** means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.

(26) **“Medical service”** means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, or other related services; drugs, medicine, crutches, prosthetic appliances, braces, and supports; and where necessary, physical restorative services.

(27) **“Medical service provider”** means a person duly licensed to practice one or more of the healing arts.

(28) **“Medical treatment”** means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker’s condition through conservative care.

(29) **“Parties”** mean the worker, insurer, MCO, attending physician, and other medical provider, unless a specific limitation or exception is expressly provided for in the statute.

(30) **“Patient”** means the same as worker as defined in ORS 656.005(28).

(31) **“Physical capacity evaluation”** means an objective, directly observed, measurement of a worker’s ability to perform a variety of physical tasks combined with subjective analyses of abilities by worker and evaluator. Physical tolerance screening, Blankenship’s Functional Capacity Evaluation, and Functional Capacity Assessment have the same meaning as Physical Capacity Evaluation.

(32) **“Physical restorative services”** means those services prescribed by the attending physician or authorized nurse practitioner to address permanent loss of physical function due to hemiplegia or a spinal cord injury, or to address residuals of a severe head injury. Services are designed to restore and maintain the patient’s highest functional ability consistent with the patient’s condition.

(33) “Report” means medical information transmitted in written form containing relevant subjective or objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the director.

(34) “Residual functional capacity” means a patient’s remaining ability to perform work-related activities. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the patient can perform each activity.

(35) “Specialist physician” means a licensed physician who qualifies as an attending physician and who examines a patient at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice or an opinion regarding the treatment being rendered, or considered, for a patient’s compensable injury.

(36) “Work capacity evaluation” means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work Tolerance Screening has the same meaning as Work Capacity Evaluation.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.000 et seq.; 656.005

Hist: Amended 3/11/19 as Admin. Order 19-052, eff. 4/1/19

Amended 11/22/23 as Admin. Order 23-055, eff. 1/1/2024

SMC (physician assistant name change) ORS 183.335(7), (WCD 5-2024) eff. 6/6/24

436-010-0008 Request for Review before the Director

(1) General.

(a) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all disputes concerning medical fees, nonpayment of compensable medical bills, and medical service and treatment disputes arising under ORS 656.245, 656.247, 656.248, 656.260, 656.325, and 656.327. Disputes about whether a medical service provided after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c), or whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review before the director.

(b) As provided in ORS 656.704(3)(b), the following disputes are in the jurisdiction of the board and will be transferred:

(A) A dispute that requires a determination of the compensability of the medical condition for which medical services are proposed; and

(B) A dispute that requires a determination of whether a sufficient causal relationship exists between medical services and an accepted claim.

(c) A party does not need to be represented to participate in the administrative review before the director.

(d) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed.

(e) All issues pertaining to disagreements about medical services within a managed care organization (MCO), including disputes under ORS 656.245(4)(a) about whether a change of provider will be medically detrimental to the worker, are subject to ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting an administrative review of the matter before the director.

(f) The director may, on the director’s own motion, initiate a review of medical services or medical treatment at any time.

(g) If the director issues an order declaring an already rendered medical treatment or medical service inappropriate, or otherwise in violation of the statute or medical rules, the worker is not obligated to pay for such.

(h) A request for administrative review under this rule may also be filed as prescribed in OAR 438-005.

(2) Time Frames and Conditions.

(a) The following time frames and conditions apply to requests for administrative review before the director under this rule:

(A) For MCO-enrolled claims, a party that disagrees with an action or decision of the MCO must first use the MCO’s dispute resolution process. If the party does not appeal the MCO’s decision using the MCO’s dispute resolution process, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision unless the party can show good cause. Good cause means circumstances that are outside the control of a party or circumstances that are considered to be extenuating by the division. When the aggrieved party is a represented worker, and the worker’s attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision.

When a party mistakenly sends an appeal of an MCO action or decision to the division, the division will forward the appeal to the MCO. The MCO must use the original mailing date of the appeal mistakenly sent to the division when determining timeliness of the appeal.

(B) For MCO-enrolled claims, if a party disagrees with the final action or decision of the MCO, the aggrieved party must request administrative review before the director within 60 days of the MCO’s final decision. When the aggrieved party is a represented worker, and the worker’s attorney had given written notice of representation to the insurer at the time the MCO issued its decision, the 60-day time frame begins when the MCO issues its final decision to the attorney. If a party has been denied access to the MCO dispute resolution process, or the process has not been completed for reasons beyond a party’s control, the party may request director review within 60 days of the failure of the MCO process. If the MCO does not have a process for resolving a particular type of dispute, the insurer or

the MCO must advise the medical provider or worker that they may request review before the director.

(C) For claims not enrolled in an MCO, or for disputes that do not involve an action or decision of an MCO, the aggrieved party must request administrative review before the director within 90 days of the date the party knew, or should have known, there was a dispute. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 90-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due. For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, whichever occurs last.

(b) Medical provider bills for treatment or services that are under review before the director are not payable during the review.

(3) Form and Required Information.

(a) Requests for administrative review before the director should be made on [Form 2842](#) as described in [Bulletin 293](#). When an insurer or a worker's representative submits a request without the required information, the director may dismiss the request or hold initiation of the administrative review until the required information is submitted. Unrepresented workers may ask the director for help in meeting the filing requirements. The requesting party must simultaneously notify all other interested parties and their representatives, if known, of the dispute. The notice must:

(A) Identify the worker's name, date of injury, insurer, and claim number;

(B) Specify the issues in dispute and the relief sought; and

(C) Provide the specific dates of the unpaid disputed treatment or services.

(b) In addition to medical evidence relating to the dispute, all parties may submit other relevant information, including written factual information, sworn affidavits, or legal argument, for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain additional evidence consistent with statute, such as pertinent medical treatment and payment records. The director may also interview parties to the dispute, or consult with an appropriate committee of the medical provider's peers. When a party receives a written request for additional information from the director, the party must respond within 14 days.

(c) When a request for administrative review is filed under ORS 656.247, 656.260, or 656.327, the insurer must provide a record packet, at no charge, to the director and all other parties or their representatives as follows:

(A) The packet must include a complete copy of the worker's medical record and other documents that are arguably related to

the medical dispute, arranged in chronological order, with oldest documents on top. The packet must include the following notice in bold type:

We hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order that could affect reimbursement for the disputed medical service(s).

(B) If the insurer requests review, the packet must accompany the request, with copies sent simultaneously to the other parties.

(C) If the requesting party is not the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer must provide the record within 14 days of the director's request as described in this rule.

(D) If the insurer fails to submit the record in the time and format specified in this rule, the director may sanction the insurer under OAR 436-010-0340.

(E) Except for disputes regarding interim medical benefits, the packet must include certification that there is or is not an issue of compensability or causation under subsection (1)(b) of this rule. If the insurer issued a denial that has been reversed by the board or the Court of Appeals, the insurer must provide a statement regarding its intention, if known, to accept or appeal the decision.

(4) Physician Review (E.g., appropriateness).

If the director determines a review by a physician is indicated to resolve the dispute, the director, under OAR 436-010-0330, may appoint an appropriate medical service provider or panel of providers to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. Notwithstanding ORS 656.325(1), if the worker is required by the director to submit to a medical exam as part of the administrative review process, the worker may refuse an invasive test without sanction.

(a) A single physician selected to conduct a review must be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment or service is being reviewed.

(b) When a panel of physicians is selected, at least one panel member must be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment or service is being reviewed.

(c) When such an exam of the worker is required, the director will notify the appropriate parties of the date, time, and location of the exam. Examinations will be at a place reasonably convenient to the worker, if possible. The parties must not directly contact the physician or panel unless it relates to the exam date, time, location, or attendance. If the parties have special questions they want addressed by the physician or panel, the questions must be submitted to the director for screening as to the appropriateness of the questions. Matters not related to the issues before the director are inappropriate for medical review and will not be submitted to the reviewing physician(s). The exam may include, but is not limited to:

(A) A review of all medical records and diagnostic tests submitted,

(B) An examination of the worker, and

(C) Any necessary and reasonable medical tests.

(5) Dispute Resolution by Agreement (E.g., Alternative Dispute Resolution).

(a) A dispute may be resolved by agreement between the parties to the dispute. The agreement must be in writing and approved by the director. The director may issue a letter of agreement instead of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) A party fails to honor the agreement;

(B) The agreement was based on misrepresentation;

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

(D) All parties request revision or reinstatement of the dispute.

(b) Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney.

(c) If the dispute does not resolve through mediation or alternative dispute resolution, the director will issue an order. If the dispute is not resolved by agreement and if the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order under ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical dispute exists, the party may appeal the order to the Workers' Compensation Board within 30 days of the mailing date of the order. Upon review, the order of the director may be modified only if it is not supported by substantial evidence in the record developed by the director.

(6) Director Order and Reconsideration.

(a) The director may, on the director's own motion, reconsider or withdraw 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 information that 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 must be received by the director before the administrative order becomes final.

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

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

(d) Attorney fees in administrative review will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 through 436-001-0440.

(7) Hearings.

(a) Any party that disagrees with an action or administrative order under these rules may obtain review of the action or order by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the action or order under ORS 656.245, 656.248, 656.260, or 656.327, or within 60 days of the mailing date of an action or order under ORS 656.247. OAR 436-001 applies to the hearing.

(b) In the review of orders issued under ORS 656.245, 656.247, 656.260(15) or (16), or 656.327(2), no new medical evidence or issues will be admitted at hearing. In these reviews, an administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(c) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254 or 656.745 may request a hearing by the board as follows:

(A) A written request for a hearing must be mailed or submitted to the division. The request must specify the grounds upon which the proposed order or assessment is contested.

(B) The request must be mailed or submitted to the division within 60 days after the mailing date of the order or notice of assessment.

(C) The division will forward the request and other pertinent information to the board.

(8) Other Proceedings.

(a) Any party seeking an action or decision by the director, or any party aggrieved by an action taken by another party not covered under sections (1) through (7) of this rule, may request administrative review before the director.

(b) A written request for review must be sent to the division within 90 days of the disputed action and must specify the grounds upon which the action is contested.

(c) The division may require and allow such input and information as it deems appropriate to complete the review.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704

Hist: Amended 12/17/19 as Admin. Order 19-061, eff. 1/1/20

436-010-0200 Medical Advisory Committee

The Medical Advisory Committee members are appointed by the director of the Department of Consumer and Business Services. The committee must include one insurer representative, one employer representative, one worker representative, one managed care organization representative, and a diverse group of health care providers representative of those providing medical care to injured or ill workers.

The director may appoint other persons as may be determined necessary to carry out the purpose of the committee. Health care providers must comprise a majority of the committee at all times. When appointing members, the director should select health care providers who will consider the perspective of specialty care, primary care, and ancillary care providers and

consider the ability of members to represent the interests of the community at large.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.794
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

436-010-0210 Attending Physician, Authorized Nurse Practitioner, and Temporary Disability Authorization

(1) An attending physician or authorized nurse practitioner is primarily responsible for the patient's care, authorizes temporary disability, and prescribes and monitors ancillary care and specialized care.

(a) No later than five days after becoming a patient's attending physician or authorized nurse practitioner, the provider must notify the insurer using [Form 827](#). Regardless of whether Form 827 is filed, the facts of the case and the actions of the provider determine if the provider is the attending physician or authorized nurse practitioner.

(b) Type A, type B, and type C attending physicians, and authorized nurse practitioners may authorize temporary disability and manage medical services subject to the limitations of ORS chapter 656 or a managed care organization contract. (See Appendix A "Matrix for Health Care Provider Types")

(c) Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be approved by the worker's attending physician or authorized nurse practitioner.

(2) Chiropractic Physicians and Naturopathic Physicians (Type B providers).

(a) Prior to providing any compensable medical service or authorizing temporary disability benefits under ORS 656.245, a type B provider must certify to the director that the provider has reviewed a packet of materials provided by the director.

(b) Type B providers may assume the role of attending physician for a cumulative total of 60 days or 18 visits, whichever occurs first, from the first visit on the initial claim with any type B provider.

(c) Type B providers may authorize payment of temporary disability compensation for a period not to exceed 30 days from the date of the first visit on the initial claim to any type B provider.

(d) Except for chiropractic physicians serving as the attending physician at the time of claim closure, type B providers may not make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.

(3) Physician Associates (Type C providers).

(a) Prior to providing any compensable medical service or authorizing temporary disability benefits under ORS 656.245, a physician associate must certify to the director that the provider has reviewed a packet of materials provided by the director.

(b) Physician associates may assume the role of attending physician for a cumulative total of 180 days from the date of the first visit on the initial claim with any physician associate.

(c) Physician associates may authorize payment of temporary disability compensation for a period not to exceed 180 days from the date of the first visit on the initial claim to any physician associate.

(d) Physician associates may not make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.

(4) Authorized Nurse Practitioners.

(a) In order to provide any compensable medical service, a nurse practitioner licensed in Oregon under ORS 678.375 to 678.390 must review a packet of materials provided by the division and complete the statement of authorization. (See www.oregonwcdoc.info) Once the nurse practitioner has completed the statement of authorization, the division will assign an authorized nurse practitioner number.

(b) An authorized nurse practitioner may:

(A) Provide compensable medical services to an injured worker for a period of 180 days from the date of the first visit with a nurse practitioner on the initial claim. Thereafter, medical services provided by an authorized nurse practitioner are not compensable without the attending physician's authorization; and

(B) Authorize temporary disability benefits for a period of up to 180 days from the date of the first nurse practitioner visit on the initial claim.

(5) Emergency Room Physicians.

Emergency room physicians may authorize temporary disability for no more than 14 days when they refer the patient to a primary care physician. If an emergency room physician sees a patient in the physician's private practice apart from their duties as an emergency room physician, the physician may be the attending physician.

(6) Unlicensed to Provide Medical Services.

Attending physicians may prescribe services to be carried out by persons not licensed to provide a medical service or treat independently. These services must be rendered under the physician's direct control and supervision. Home health care provided by a patient's family member is not required to be provided under the direct control and supervision of the attending physician if the family member demonstrates competency to the satisfaction of the attending physician.

(7) Out-of-State Attending Physicians.

The worker may choose an attending physician outside the state of Oregon with the approval of the insurer. When the insurer receives the worker's request or becomes aware of the worker's request to treat with an out-of-state attending physician, the insurer must give the worker written notice of approval or disapproval of the worker's choice of attending physician within 14 days. If an approved out-of-state attending physician does not comply with OAR 436-009 or 436-010, the insurer may withdraw approval of the attending physician.

(a) If the insurer approves the worker's choice of out-of-state attending physician, the insurer must immediately notify the worker and the physician in writing of the following:

(A) The Oregon medical fee and payment rules, OAR 436-009;

(B) The manner in which the out-of-state physician may provide compensable medical treatment or services to Oregon workers; and

(C) That the insurer cannot pay bills for compensable services above the Oregon fee schedule.

(b) If the insurer disapproves the worker's out-of-state attending physician or withdraws a prior approval, the insurer must send the worker written notice that:

(A) Clearly states the reasons for the disapproval or withdrawal of the prior approval, for example, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010;

(B) Identifies at least two other physicians of the same healing art and specialty in the same area that the insurer would approve;

(C) Informs the worker that if the worker disagrees with the disapproval or withdrawal, the worker may request approval from the director under OAR 436-010-0220; and

(D) Informs the worker that the worker may be liable for payment of services provided after the date of notification if the worker receives further medical services from the disapproved or no longer approved out-of-state physician.

(c) If the insurer withdraws approval of the out-of-state attending physician, the insurer must notify the physician of the following in writing:

(A) The reasons for withdrawing the approval;

(B) That any future services provided by that physician will not be paid by the insurer; and

(C) That the worker may be liable for payment of services provided after the date of notification.

(d) The worker or worker's representative may request approval from the director under OAR 436-010-0220 if the worker disagrees with the insurer's decision to:

(A) Disapprove an out-of-state attending physician; or

(B) Withdraw the approval of the out-of-state attending physician.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.005(12), 656.245, 656.260, 656.799

Hist: Amended 6/13/22 as Admin. Order 22-054, eff. 7/1/22

Amended 11/22/23 as Admin. Order 23-055, eff. 1/1/2024

SMC (physician assistant name change) ORS 183.335(7), (WCD 6-2024) eff. 6/6/24

436-010-0220 Choosing and Changing Medical Providers

(1) The worker may have only one attending physician or authorized nurse practitioner at a time. Concurrent treatment or services by other medical providers, including specialist physicians, must be sufficiently different that separate medical skills are needed for proper care, and must be based on a written referral by the attending physician or authorized nurse practitioner. The referral must specify any limitations and a copy must be sent to the insurer. A specialist physician is

authorized to provide or order all compensable medical services and treatment the physician considers appropriate, unless the referral is for a consultation only. The attending physician or authorized nurse practitioner continues to be responsible for authorizing temporary disability even if the specialist physician is providing or authorizing medical services and treatment.

Physicians who provide the following services are not considered attending physicians:

(a) Emergency services;

(b) Insurer or director requested examinations;

(c) A Worker Requested Medical Examination;

(d) Consultations or referrals for specialized treatment or services initiated by the attending physician or authorized nurse practitioner; and

(e) Diagnostic studies provided by radiologists and pathologists upon referral.

(2) Changing Attending Physician or Authorized Nurse Practitioner.

The worker may choose to change attending physician or authorized nurse practitioner only twice after the initial choice. When the worker requests a referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, the change will count as one of the worker's choices. The limitation of the worker's right to choose attending physicians or authorized nurse practitioners begins with the date of injury and extends through the life of the claim. The following are not considered changes of attending physician or authorized nurse practitioner initiated by the worker and do not count toward the worker's two changes:

(a) When the worker has an attending physician or authorized nurse practitioner who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines;

(b) When the worker's attending physician or authorized nurse practitioner is not available and the worker sees a medical provider who is covering for that provider in their absence; or

(c) When the worker is required to change attending physician or authorized nurse practitioner due to conditions beyond the worker's control. This could include, but is not limited to:

(A) When the attending physician or authorized nurse practitioner terminates practice or leaves the area;

(B) When the attending physician or authorized nurse practitioner is no longer willing to treat the worker;

(C) When the worker moves out of the area requiring more than a 50 mile commute to the attending physician or authorized nurse practitioner;

(D) When the period for treatment or services by a type B or type C attending physician or an authorized nurse practitioner has expired (See Appendix A "Matrix for Health Care Provider Types");

(E) When the physician associate or authorized nurse practitioner is required to refer the worker to an attending physician for a closing examination or because of a possible worsening of the worker's condition following claim closure;

(F) When the worker becomes subject to a managed care organization (MCO) contract and must change to an attending physician or authorized nurse practitioner on the MCO's panel;

(G) When the worker who, at the time of MCO enrollment was required to change attending physician or authorized nurse practitioner, is disenrolled from an MCO; or

(H) When the worker has to change because their attending physician or authorized nurse practitioner is no longer qualified as an attending physician or authorized to continue providing compensable medical services.

(3) Insurer Notice to the Worker.

When the worker has changed attending physicians or authorized nurse practitioners twice by choice or has reached the maximum number of changes established by the MCO, the insurer must notify the worker by certified mail that any additional changes by choice must be approved by the insurer or the director. If the insurer fails to provide such notice and the worker later chooses another attending physician or authorized nurse practitioner, the insurer must pay for compensable medical services rendered prior to notice to the worker. The insurer must notify the newly selected provider that the worker was not allowed to change attending physician or authorized nurse practitioner without approval of the insurer or director, and therefore any future services will not be paid. The insurer must pay for appropriate medical services rendered prior to this notification.

(4) Worker Requesting Additional Changes of Attending Physician or Authorized Nurse Practitioner.

(a) If a worker not enrolled in an MCO has changed attending physicians or authorized nurse practitioners by choice twice (or for MCO enrolled workers, the maximum allowed by the MCO) and wants to change again, the worker must request approval from the insurer. The worker must make the request in writing or by signing [Form 827](#). The insurer must respond to the worker within 14 days of receiving the request whether the change is approved. If the insurer objects to the change, the insurer must:

(A) Send the worker a written explanation of the reasons;

(B) Send the worker [Form 2332](#) (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner); and

(C) Inform the worker that the worker may request director approval by sending [Form 2332](#) to the director.

(b) When the worker submits a request to the director for an additional change of attending physician or authorized nurse practitioner, the director may request, in writing, additional information. If the director requests additional information, the parties must respond in writing within 14 days of the director's request.

(c) The director will issue an order advising whether the request for change of attending physician or authorized nurse practitioner is approved. On a case-by-case basis the director will consider circumstances, such as:

(A) Whether there is medical justification for a change, e.g., whether the attending physician or authorized nurse practitioner

can provide the type of treatment or service that is appropriate for the worker's condition.

(B) Whether the worker has moved to a new area and wants to establish an attending physician or authorized nurse practitioner closer to the worker's residence.

(d) Any party that disagrees with the director's order may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order.

(5) Managed Care Organization (MCO) Enrolled Workers.

(a) An MCO enrolled worker must choose:

(A) A panel provider unless the MCO approves a non-panel provider, or

(B) A "come-along provider" who provides medical services subject to the terms and conditions of the governing MCO.

(b) Notwithstanding subsection (a) of this section, if a worker is unable to find three providers that are willing to treat the worker in a category of providers listed in OAR 436-015-0030(6)(a) and (b) in the worker's geographic service area (GSA), the worker may contact the MCO for a list of three providers who are willing to treat the worker. If the MCO, within 14 days, is unable to provide a list of three providers who are willing to treat the worker within a reasonable period of time, the worker may choose a non-panel provider in that category.

(c) Notwithstanding subsection (a) of this section, if the MCO has fewer than three providers in a category of providers listed in OAR 436-015-0030(6)(a) and (b) in the worker's GSA, the worker may choose a non-panel provider in that category.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.252, 656.260

Hist: Amended 6/13/22 as Admin. Order 22-054, eff. 7/1/22

Amended 11/22/23 as Admin. Order 23-055, eff. 1/1/2024

Amended 3/5/24 as Admin. Order 24-051, eff. 4/1/24

SMC (physician assistant name change) ORS 183.335(7), (WCD 7-2024) eff. 6/6/24

436-010-0225 Choosing a Person to Provide Interpreter Services

(1) A worker may choose a person to communicate with a medical provider when the worker and the medical provider speak different languages, including sign language. The worker may choose a family member, a friend, an employee of the medical provider, or someone who provides interpreter services as a profession. However, for signed language interpretation services, the worker may only choose an interpreter who is a medical sign language interpreter licensed under ORS 676.765.

A representative of the worker's employer may not provide interpreter services. The medical provider may disapprove of the worker's choice at any time the medical provider feels the interpreter services are not improving communication with the worker, or feels the interpretation is not complete or accurate.

(2) When a worker asks an insurer to arrange for interpreter services, the insurer must:

(a) For interpretation services, other than signed language interpretation services, use a certified or qualified health care interpreter listed on the Oregon Health Care Interpreter Registry

of the Oregon Health Authority, available at:

<http://www.oregon.gov/OHA/OEL/Pages/HCI-Program.aspx>.

The interpreter's certification or qualification must be in effect on the date the interpreter services are provided. If no certified or qualified health care interpreter is available, the insurer may schedule an interpreter of its choice subject to the limits in section (1) of this rule.

(b) For signed language interpretation services, use a sign language interpreter licensed under ORS 676.750 to 676.789.

(3) Prior to offering interpreter services by a health care interpreter employed by the medical provider, the medical provider must inform the worker of the worker's right to choose an interpreter.

(4) For the purpose of this rule, interpreter services means the act of orally translating between a medical provider and a patient who speak different languages, including sign language. It includes reasonable time spent waiting at the location for the medical provider to examine or treat the patient as well as reasonable time spent on necessary paperwork for the provider's office.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245

Hist: Amended 11/22/23 as Admin. Order 23-055, eff. 1/1/2024

Amended 3/11/25 as Admin. Order 24-051, eff. 4/1/25

436-010-0230 Medical Services and Treatment Guidelines

(1) Medical services provided to the worker must not be more than the nature of the compensable injury or the process of recovery requires. Services that are unnecessary or inappropriate according to accepted professional standards are not reimbursable.

(2) If the provider's chart notes do not provide evidence of frequency, extent, and efficacy of treatment and services, the insurer may request additional information from the provider.

(3) All medical service providers must notify the patient at the time of the first visit of how they can provide compensable medical services and authorize temporary disability. Providers must also notify patients that they may be personally liable for noncompensable medical services. Such notification should be made in writing or documented in the patient's medical record.

(4) Consent to Attend a Medical Appointment.

(a) An employer or insurer representative, such as a nurse case manager, may not attend a patient's medical appointment without written consent of the patient. The patient has the right to refuse such attendance.

(A) The consent form must be written in a way that allows the patient to understand it and to overcome language or cultural differences.

(B) The consent form must state that the patient's benefits cannot be suspended if the patient refuses to have an employer or insurer representative present.

(C) The insurer must keep a copy of the signed consent form in the claim file.

(b) The patient or the medical provider may refuse to allow an employer or insurer representative to attend an appointment at

any time, even if the patient previously signed a consent form. The medical provider may refuse to meet with the employer or insurer representative.

(5) Request for Records at a Medical Appointment.

The medical provider may refuse to provide copies of the patient's medical records to the insurer representative without proof that the person is representing the insurer. The provider may charge for any copies that are provided.

(6) Requesting a Medical Provider Consultation.

The attending physician, authorized nurse practitioner, or the MCO may request a consultation with a medical provider regarding conditions related to an accepted claim. MCO-requested consultations that are initiated by the insurer, which include an exam of the worker, must be considered independent medical exams under OAR 436-010-0265.

(7) Ancillary Services – Treatment Plan.

(a) Ancillary medical service providers include but are not limited to physical or occupational therapists, chiropractic or naturopathic physicians, and acupuncturists. When an attending or specialist physician or an authorized nurse practitioner prescribes ancillary services, unless an MCO contract specifies other requirements, the ancillary provider must prepare a treatment plan before beginning treatment.

(b) The ancillary medical service provider must send the treatment plan to the prescribing provider and the insurer within seven days of beginning treatment. If the treatment plan is not sent within seven days, the insurer is not required to pay for the services provided before the treatment plan is sent.

(c) The treatment plan must include objectives, modalities, frequency of treatment, and duration. The treatment plan may be in any legible format, e.g., chart notes. If the ancillary treatment needs to continue beyond the duration stated in the treatment plan, the ancillary care provider must obtain a new prescription from the attending or specialist physician or authorized nurse practitioner to continue treatment. The ancillary care provider also must send a new treatment plan to the insurer and the prescribing physician within seven days.

(d) Treatment plans required under this subsection do not apply to services provided under ORS 656.245(2)(b)(A). (See Appendix A "Other Health Care Providers.")

(e) Within 30 days of the beginning of ancillary services, the prescribing provider must sign a copy of the treatment plan and send it to the insurer. If the prescribing provider does not sign and send the treatment plan, the provider may be subject to sanctions under OAR 436-010-0340. However, this will not affect payment to the ancillary provider.

(f) Authorized nurse practitioners, out-of-state nurse practitioners, and physician associates directed by the attending physician do not have to provide a written treatment plan as prescribed in this section.

(8) Massage Therapy.

Unless otherwise provided by an MCO, when an attending physician, authorized nurse practitioner, or specialist physician prescribes ancillary services provided by a massage therapist

licensed by the Oregon State Board of Massage Therapists under ORS 687.011 to 687.250, the massage therapist must prepare a treatment plan before beginning treatment. Massage therapists not licensed in Oregon must provide their services under the direct control and supervision of the attending physician. Treatment plans provided by massage therapists must follow the same requirements as those for ancillary providers in section (7) of this rule.

(9) Therapy Guidelines and Requirements.

(a) Unless otherwise provided by an MCO's utilization and treatment standards, the usual range for therapy visits is up to 20 visits in the first 60 days, and four visits a month thereafter. This is only a guideline and insurers should not arbitrarily limit payment based on this guideline nor should the therapist arbitrarily use this guideline to exceed medically necessary treatment. The medical record must provide clinical justification when therapy services exceed these guidelines. When an insurer believes the treatment is inappropriate or excessive, the insurer may request director review as outlined in OAR 436-010-0008.

(b) Unless otherwise provided by an MCO, a physical therapist must submit a progress report to the attending physician (or authorized nurse practitioner) and the insurer every 30 days or, if the patient is seen less frequently, after every visit. The progress report may be part of the physical therapist's chart notes and must include:

- (A) Subjective status of the patient;
- (B) Objective data from tests and measurements conducted;
- (C) Functional status of the patient;
- (D) Interpretation of above data; and
- (E) Any change in the treatment plan.

(10) Physical Capacity Evaluation.

The attending physician or authorized nurse practitioner must complete a physical capacity or work capacity evaluation within 20 days after the insurer or director requests the evaluation. If the attending physician or authorized nurse practitioner does not wish to perform the evaluation, they must refer the patient to a different provider within seven days of the request. The attending physician or authorized nurse practitioner must notify the insurer and the patient in writing if the patient is incapable of participating in the evaluation.

(11) Prescription Medication.

(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the worker is medically stationary. For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available) according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must pay the total cost of the brand-name drug out-of-pocket and request reimbursement from the insurer. However, if the insurer has previously notified the worker that the worker is liable for the difference between

the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug. Except in an emergency, prescription drugs for oral consumption dispensed by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker, up to a maximum of 10 days. Unless otherwise provided by an MCO contract, the worker may choose the dispensing provider.

(b) Providers should review and are encouraged to adhere to the division's opioid guidelines. See <https://wcd.oregon.gov/medical/provider-training/Pages/opioid-guidelines.aspx>.

(12) Diagnostics.

Unless otherwise provided by an MCO, a medical provider may contact an insurer in writing for pre-authorization of diagnostic imaging studies other than plain film X-rays. The request must be separate from chart notes and clearly state that it is a request for pre-authorization of diagnostic imaging studies. Pre-authorization is not a guarantee of payment. The insurer must respond to the provider's request in writing whether the service is pre-authorized or not pre-authorized within 14 days of receipt of the request.

(13) Articles.

Articles, including but not limited to, beds, hot tubs, chairs, and gravity traction devices are not compensable unless a report by the attending physician or authorized nurse practitioner clearly justifies the need. The report must:

- (a) Establish that the nature of the injury or the process of recovery requires the item be furnished, and
- (b) Specifically explain why the worker requires the item when the great majority of workers with similar impairments do not.

(14) Physical Restorative Services.

(a) Physical restorative services include, but are not limited to, a regular exercise program, personal exercise training, or swim therapy. They are not services to replace medical services usually prescribed during the course of recovery. Physical restorative services are not compensable unless:

- (A) The nature of the worker's limitations requires specialized services to allow the worker a reasonable level of social or functional activity, and
- (B) A report by the attending physician or authorized nurse practitioner clearly justifies why the worker requires services not usually considered necessary for the majority of workers.

(b) Trips to spas, resorts, or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

(15) Lumbar Artificial Disc Replacement Guidelines.

(a) Lumbar artificial disc replacement is always inappropriate for patients with the following conditions (absolute contraindications):

- (A) Metabolic bone disease – for example, osteoporosis;

- (B) Known spondyloarthropathy (seropositive and seronegative);
 - (C) Posttraumatic vertebral body deformity at the level of the proposed surgery;
 - (D) Malignancy of the spine;
 - (E) Implant allergy to the materials involved in the artificial disc;
 - (F) Pregnancy – currently;
 - (G) Active infection, local or systemic;
 - (H) Lumbar spondylolisthesis or lumbar spondylolysis;
 - (I) Prior fusion, laminectomy that involves any part of the facet joint, or facetectomy at the same level as proposed surgery; or
 - (J) Spinal stenosis – lumbar – moderate to severe lateral recess and central stenosis.
- (b) Lumbar artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(g) may be inappropriate for patients with the following conditions, depending on severity, location, etc. (relative contraindications):
- (A) A comorbid medical condition compromising general health, for example, hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS, lupus, etc.;
 - (B) Arachnoiditis;
 - (C) Corticosteroid use (chronic ongoing treatment with adrenal immunosuppression);
 - (D) Facet arthropathy – lumbar – moderate to severe, as shown radiographically;
 - (E) Morbid obesity – BMI greater than 40;
 - (F) Multilevel degenerative disc disease – lumbar – moderate to severe, as shown radiographically;
 - (G) Osteopenia – based on bone density test;
 - (H) Prior lumbar fusion at a different level than the proposed artificial disc replacement; or
 - (I) Psychosocial disorders – diagnosed as significant to severe.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252
Hist: Amended 3/3/21 as Admin. Order 21-052, eff. 4/1/21
Amended 11/22/23 as Admin. Order 23-055, eff. 1/1/2024
SMC (physician assistant name change) ORS 183.335(7), (WCD 8-2024) eff. 6/6/24

436-010-0240 Medical Records and Reporting Requirements for Medical Providers

(1) Medical Records and Reports.

- (a) Medical providers must maintain records necessary to document the extent of medical services provided.
- (b) All records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.
- (c) Reports may be handwritten and must include all relevant or requested information such as the anticipated date of release to return to work, medically stationary date, etc.

(d) Diagnoses stated on all reports, including [Form 827](#), must conform to terminology found in the appropriate International Classification of Disease (ICD).

(2) Diagnostic Studies.

When the director or the insurer requests original diagnostic studies, including but not limited to actual films, they must be forwarded to the director, the insurer, or the insurer's designee within 14 days of receipt of a written request.

(a) Diagnostic studies, including films, must be returned to the medical provider within a reasonable time.

(b) The insurer must pay a reasonable charge made by the medical provider for the costs of delivery of diagnostic studies, including films.

(3) Multidisciplinary Programs.

When an attending physician or authorized nurse practitioner approves a multidisciplinary treatment program for the worker, the attending physician or authorized nurse practitioner must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.

(4) Release of Medical Records.

(a) Health Insurance Portability and Accountability Act (HIPAA) rules allow medical providers to release information to insurers, self-insured employers, service companies, or the Department of Consumer and Business Services. [See 45 CFR 164.512(l).]

(b) When patients file workers' compensation claims they are authorizing medical providers and other custodians of claim records to release relevant medical records including diagnostics. The medical provider will not incur any legal liability for disclosing such records. [See ORS 656.252(4).] The authorization is valid for the life of the claim and cannot be revoked by the patient or the patient's representative. A separate authorization is required for release of information regarding:

(A) Federally funded drug and alcohol abuse treatment programs governed by Federal Regulation 42, CFR 2, which may only be obtained in compliance with this federal regulation, and

(B) HIV-related information protected by ORS 433.045.

(c) Any medical provider must provide all relevant information to the director, or the insurer or its representative upon presentation of a signed [Form 801](#), [827](#), or [2476](#). The insurer may print "Signature on file" on a release form as long as the insurer maintains a signed original. However, the medical provider may require a copy of the signed release form.

(d) The medical provider must respond within 14 days of receipt of a request for progress reports, narrative reports, diagnostic studies, or relevant medical records needed to review the efficacy, frequency, and necessity of medical treatment or medical services. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part.

(e) Workers or their representatives are entitled to copies of all medical and payment records, which may include records from other medical providers. Workers or their representatives may request all or part of the record. These records should be requested from the insurer, but may also be obtained from medical providers. Insurers must respond to the workers' or their representatives' request within the timeframes provided in OAR 436-060-0017(5). Medical providers must respond within 14 days of receipt of a request from workers or their representatives for medical or payment records. A summary may substitute for the actual record only if the worker agrees to the substitution. The following records may be withheld:

- (A) Psychotherapy notes;
- (B) Information compiled for use in a civil, criminal, or administrative action or proceeding;
- (C) Other reasons specified by federal regulation; and
- (D) Information that was obtained from someone other than a medical provider when the medical provider promised confidentiality and release of the information would likely reveal the source of the information.

(f) A medical provider may charge the patient or the patient's representative for copies at the rate specified in OAR 436-009-0060. A patient may not be denied summaries or copies of the patient's medical records because of inability to pay.

(g) A medical provider is encouraged to discuss potential modified work duties with employers. However, a medical provider may not discuss medical treatments or diagnoses with employers, or release medical records other than work release documentation, to employer representatives who are not directly responsible for claims processing responsibilities. This subsection does not relieve a medical provider from the requirements outlined in subsections (a) through (d) of this section.

(5) Release to Return to Work.

(a) When requested by the insurer, the attending physician or authorized nurse practitioner must submit verification that the patient's medical limitations related to their ability to work result from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return-to-work form, the insurer must use [Form 3245](#).

(b) The attending physician or authorized nurse practitioner must advise the patient, and within five days, provide the insurer written notice of the date the patient is released to return to regular or modified work.

(6) Temporary Disability and Medically Stationary.

(a) When temporary disability is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report.

The provider must submit a requested progress report or narrative report within 14 days of receiving the insurer's

request. If the medical provider fails to provide information under this rule within 14 days of receiving a request sent by fax or certified mail, penalties under OAR 436-010-0340 may be imposed.

(b) The attending physician or authorized nurse practitioner must, if known, inform the patient and the insurer of the following and include it in each progress report:

- (A) The anticipated date of release to work;
- (B) The anticipated date the patient will become medically stationary;
- (C) The next appointment date; and
- (D) The patient's medical limitations.

(c) The insurer must not consider the anticipated date of becoming medically stationary as a date of release to return to work.

(d) The attending physician or authorized nurse practitioner must notify the patient, insurer, and all other medical providers involved in the patient's treatment when the patient is determined medically stationary and whether the patient is released to any kind of work. The medically stationary date must be the date of the exam and not a projected date.

(7) Consultations.

When the attending physician, authorized nurse practitioner, or the MCO requests a consultation with a medical provider regarding conditions related to an accepted claim:

(a) The attending physician, authorized nurse practitioner, or the MCO must promptly notify the insurer of the request for the consultation and provide the consultant with all relevant medical records. However, if the consultation is for diagnostic studies performed by radiologists or pathologists, no such notification is required.

(b) The consultant must submit a copy of the consultation report to the insurer and the attending physician, authorized nurse practitioner, or MCO within 10 days of the date of the exam or chart review. The consultation fee includes the fee for this report.

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.245, 656.252, 656.254

Hist: Amended 3/9/23 as Admin. Order 23-051, eff. 4/1/23

Amended 3/5/24 as Admin. Order 24-051, eff. 4/1/24

436-010-0241 Form 827, Worker's and Health Care Provider's Report for Workers' Compensation Claims

(1) First Visit.

(a) When the patient has filed an initial claim or wants to file an initial claim, the patient and the first medical service provider must complete and sign [Form 827](#). The provider must send the form to the insurer no later than 72 hours after the patient's first visit. Saturdays, Sundays, and legal holidays are not counted in the 72-hour period. Legal holidays are those listed in ORS 187.010 and 187.020.

(b) [Form 3283](#) ("A Guide for Workers Recently Hurt on the Job") is included with [Form 827](#). All medical service providers must give a copy of [Form 3283](#) and [Form 827](#) to the patient.

(2) New or Omitted Medical Condition.

A patient may use [Form 827](#) to request that the insurer formally accept a new or omitted medical condition. If the patient uses the form to request acceptance of a new or omitted medical condition during a medical visit, the medical service provider may write the claimed condition or the appropriate International Classification of Diseases (ICD) diagnosis code for the patient in the space provided on the form. After the patient signs the form, the provider must send it to the insurer within five days.

(3) Change of Attending Physician.

When the patient changes attending physician or authorized nurse practitioner, the patient and the new medical service provider must complete and sign [Form 827](#). The provider must send Form 827 to the insurer within five days after becoming a patient's attending physician or authorized nurse practitioner. The new attending physician or authorized nurse practitioner is responsible for requesting all available medical records from the previous attending physician, authorized nurse practitioner, or insurer. Anyone failing to forward the requested information to the new attending physician or authorized nurse practitioner within 14 days of receiving the request may be subject to sanctions under OAR 436-010-0340.

(4) Aggravation.

After the patient has been declared medically stationary, and an exam reveals an aggravation of the patient's accepted condition, the patient may file a claim for aggravation. The patient or the patient's representative and the attending physician must complete and sign [Form 827](#). The physician, on the patient's behalf, must submit Form 827 to the insurer within five days of the exam. Within 14 days of the exam, the attending physician must send a written report to the insurer that includes objective findings that document:

(a) Whether the patient has suffered a worsened condition attributable to the compensable injury under the criteria in ORS 656.273; and

(b) Whether the patient is unable to work as a result of the compensable worsening.

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.245, 656.252, 656.254, 656.273

Hist: Amended 3/2/22 as Admin. Order 22-051, eff. 4/1/22

436-010-0250 Elective Surgery

(1) "Elective surgery" is surgery that may be required to recover from an injury or illness, but is not an emergency surgery to preserve life, function, or health.

(2) Except as otherwise provided by the MCO:

(a) The attending physician, authorized nurse practitioner, or specialist physician must give the insurer at least seven days notice before the date of the proposed elective surgery to treat a compensable injury or illness. The notice must provide the medical information that substantiates the need for surgery, and the approximate surgical date and place if known. To notify the insurer of the proposed surgery, the provider has the option of using [Form 5425](#) (Elective Surgery Notification) or using their own form that includes the data gathered on [Form 5425](#).

(b) When elective surgery is proposed, the insurer may require an independent consultation (second opinion) with a physician of the insurer's choice.

(c) The insurer must respond to the recommending physician, the worker, and the worker's representative within seven days of receiving the notice of intent to perform surgery that the proposed surgery:

(A) Is approved;

(B) Is not approved and a consultation is requested by using [Form 3228](#) (Elective Surgery Response); or

(C) Is disapproved by using [Form 3228](#).

(d) If the insurer does not complete [Form 3228](#) (e.g., no specific date or consultant name) or communicate approval to the recommending physician within seven days of receiving the notice of intent to perform surgery, the insurer is barred from challenging the appropriateness of the surgery or whether the surgery is excessive or ineffectual. The attending physician and the worker may decide whether to proceed with surgery.

(e) If the insurer requests a consultation, it must be completed within 28 days after sending [Form 3228](#) to the physician.

(f) The insurer must notify the recommending physician of the consultant's findings within seven days of the consultation.

(g) When the consultant disagrees with the proposed surgery, the recommending physician and insurer should attempt to resolve disagreement. The insurer and recommending physician may agree to obtain additional diagnostic testing or other medical information, such as asking for clarification from the consultant, to assist in reaching an agreement regarding the proposed surgery.

(h) If the recommending physician cannot reach an agreement with the insurer and continues to recommend the proposed surgery, the physician must send either the signed and dated [Form 3228](#) or other written notification to the insurer, the patient, and the patient's representative. If the insurer believes the proposed surgery is excessive, inappropriate, ineffectual, or in violation of these rules, the insurer must request administrative review before the director within 21 days of receiving the notification. If the insurer fails to timely request administrative review the insurer is barred from challenging whether the surgery is or was excessive, inappropriate, or ineffectual. The attending physician and the worker may decide whether to proceed with surgery.

(i) A recommending physician who prescribes or performs elective surgery and fails to give the insurer the seven day notice requirement may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340. The insurer may still be responsible to pay for the elective surgery.

(j) Surgery that must be performed before seven days, because the condition is life threatening or there is rapidly progressing deterioration or acute pain not manageable without surgical intervention, is not considered elective surgery. In such cases, the attending physician or authorized nurse practitioner should try to notify the insurer of the need for emergency surgery.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.260, 656.327

**OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICES**

**Administrative
Order No.
25-051**

Hist: Amended 3/11/19 as Admin. Order 19-052, eff. 4/1/19

436-010-0265 Independent Medical Exams (IMEs) and Worker Requested Medical Exams (WRMEs)

(1) General.

(a) An independent medical exam (IME) means any medical exam (including a physical capacity or work capacity evaluation or consultation that includes an exam) that is requested by the insurer under ORS 656.325, except as provided in section (13) of this rule. A worker requested medical exam (WRME) is an exam available to a worker under ORS 656.325. An IME or WRME is completed by a medical service provider other than the worker's attending physician or authorized nurse practitioner.

(b) The insurer may obtain three IMEs for each opening of the claim without authorization by the director. These IMEs may be obtained before or after claim closure. For the purpose of determining the number of IMEs, any IME scheduled but not completed does not count as one of the three IMEs. A claim for aggravation, Board's Own Motion, or reopening of a claim when the worker becomes enrolled or actively engaged in training under OAR 436-120 (Vocational Assistance to Injured Workers) allows a new series of three IMEs. Refer to section (12) of this rule to request additional IMEs.

(c) The IME may be conducted by one or more providers of different specialties, generally performed at one location. If the providers are not at one location, the IME must be at locations reasonably convenient to the worker. IMEs completed within a 72-hour period count as one IME.

(d) The insurer must choose the medical service provider from the director's list of authorized IME providers online at www.oregonwcdoc.info. If a provider is not on the director's list of authorized IME providers at the time of the IME, the insurer may not use the IME report and the report may not be used in any subsequent proceedings.

(e) The provider will determine the conditions under which the IME will be conducted. The IME should be performed in a professional setting that is primarily used for conducting exams. If an IME is not performed in a professional setting that is primarily used for conducting exams, the IME location should be a safe and secure environment, including a place for the worker to disrobe in private, and allow for confidentiality.

(f) IMEs must be scheduled at times and intervals reasonably convenient to the worker and must not delay or interrupt medical treatment that the worker has scheduled.

(g) The insurer must comply with the notification and reimbursement requirements under OAR 436-009-0025 and 436-060-0095.

(h) A medical service provider must not unreasonably interfere with the right of the insurer to obtain an IME by a medical service provider of the insurer's choice.

(i) A medical provider who unreasonably fails to provide diagnostic records for an IME under OAR 436-010-0240 may be assessed a penalty under ORS 656.325.

(j) The worker may complete an online survey at www.wcdimesurvey.info or make a complaint about the IME on the division's website. If the worker does not have access to the Internet, the worker may call the division at 800-452-0288.

(2) IME and WRME Provider Authorization and Removal.

(a) Medical service providers can perform IMEs, WRMEs, or both once they are on the director's list of authorized IME providers.

(b) To be on the director's list of authorized IME providers, a medical service provider must:

(A) Complete the online application available at www.oregonwcdoc.info;

(B) Hold a current license with the provider's professional regulatory licensing board;

(C) Be in good standing as determined by the division. For the purpose of this paragraph, the division determines good standing to mean the provider is not currently, or within the past two years has not been subject to, a disciplinary action or stipulated agreement with the provider's regulatory licensing board that the division determines to be detrimental to performing IMEs; and

(D) Complete the director's Training Guide to Performing Independent Medical Exams including the corresponding quiz both of which are available at www.oregonwcdoc.info; or

(E) Complete a director-approved training course regarding IMEs provided by an outside vendor.

(c) By submitting the application to the division, the medical service provider agrees to abide by:

(A) The standards of professional conduct for performing IMEs adopted by the provider's regulatory licensing board or the IME standards of professional conduct published in Appendix B if the provider's regulatory licensing board does not have standards of professional conduct for performing IMEs; and

(B) All relevant workers' compensation laws and rules.

(d) A provider may be removed from the director's list of authorized IME providers after the director finds that the provider:

(A) Violated the standards of either the professional conduct for performing IMEs adopted by the provider's regulatory licensing board or the IME standards published in Appendix B if the provider's regulatory licensing board does not have IME standards;

(B) Has a current restriction on their license or is under a current disciplinary action from their professional regulatory licensing board; or

(C) Has entered into a voluntary agreement with their regulatory licensing board that the director determines is detrimental to performing IMEs.

(e) A provider may appeal the director's decision to remove the provider from the director's list within 60 days of the mailing date of the order under ORS 656.704(2) and OAR 436-001-0019.

(3) IME Complaint Process.

(a) A complaint about an IME may be submitted to the division for investigation.

(b) The division reviews IME complaints to determine the appropriate action under the director's jurisdiction.

(c) The division investigates IME complaints to determine if there is a violation of one or more of the standards of professional conduct or workers' compensation laws or rules.

(d) If the division determines additional information is needed the division will contact the IME provider regarding the allegations in the complaint and request:

(A) A written response regarding the allegations;

(B) A copy of the IME report;

(C) Contact information for scribes, chaperones, or other people attending the IME at the IME provider's request; or

(D) A copy of a video or audio recording of the IME, if the IME was recorded.

(e) If the division does not receive a response to information requested under subsection (d) within 14 days from the date of the request, the division may make a decision based on available information.

(f) The division may contact any person who may have information or view any documentation or items regarding the IME or complaint.

(g) The division will notify the IME provider and complainant in writing of the outcome of the IME investigation.

(h) When investigating a new complaint regarding an IME provider, the division will review all complaints about that provider received in the past two years, excluding complaints where the director found no violation, to determine if there is a pattern of behavior involving the IME provider. If there is a pattern of behavior, the director may take additional action, up to and including removal of the provider from the director's list of authorized IME providers.

(i) An order issued by the director to remove an IME provider from the director's list of authorized IME providers will include a notice of appeal rights under ORS 656.704(2) and OAR 436-001-0019.

(4) IME Training.

An outside vendor may provide initial IME training to providers wanting to become an IME provider, as long as the training is approved by the director before it is provided.

(5) IME Related Forms.

(a) When scheduling an IME, the insurer must ensure the medical service provider has:

(A) [Form 3923](#), "Important Information about Independent Medical Exams," available to the worker before the exam; and

(B) [Form 3227](#), "Invasive Medical Procedure Authorization," if applicable.

(b) The IME provider must make [Form 3923](#) with the attached observer Form [3923A](#) available to the worker.

(6) IME Observer.

(a) A worker may choose to have an observer present during the IME. An observer is not allowed to be present during a psychological examination unless the IME provider approves.

(b) The worker's observer must not be paid to attend the IME. The worker's attorney or any representative of the worker's attorney may not be an observer.

(c) If the observer interferes with or obstructs the IME, the IME provider may ask the observer to leave and continue the IME with the worker's consent or end the IME.

(d) If the worker chooses to have an observer present, the provider must verify that the worker has signed [Form 3923A](#), "IME Observer Form," acknowledging that the worker understands:

(A) The IME provider may ask sensitive questions during the exam in the presence of the observer;

(B) If the observer interferes with the exam, the IME provider may stop the exam, which could affect the worker's benefits; and

(C) The observer must not be paid to attend the exam.

(7) Invasive Procedure.

(a) For the purposes of this rule, an invasive procedure is one that breaks the skin or penetrates, pierces, or enters the body using a surgical or exploratory procedure (e.g., by a needle, tube, scope, or scalpel). If an IME provider intends to perform an invasive procedure, the provider must explain to the worker the risks involved in the procedure and the worker's right to refuse the procedure. The worker must check the applicable box on [Form 3227](#), "Invasive Medical Procedure Authorization," either agreeing to the procedure or declining the procedure and sign the form. The IME provider must make a copy of the signed Form 3227 for the worker and send the original to the insurer.

(b) An IME provider may be sanctioned under OAR 436-010-0340(1) for failing to follow this section.

(8) Recording the IME.

With the IME provider's approval, the worker may use a video camera or other device to record the IME.

(9) Objection to the IME Location.

When a worker objects to the location of an IME, the worker may request review before the director within six business days of the mailing date of the appointment notice.

(a) The request may be made in-person, by telephone, fax, email, or mail.

(b) The director may facilitate an agreement between the parties regarding location.

(c) If necessary, the director will conduct an expedited review and issue an order regarding the reasonableness of the location.

(d) The director will determine if travel is medically contraindicated or unreasonable because:

(A) The travel exceeds limitations imposed by the attending physician, authorized nurse practitioner, or any medical conditions;

(B) Alternative methods of travel will not overcome the limitations; or

(C) The travel would impose undue hardship for the worker that outweighs the right of the insurer to select an IME location of its choice.

(10) Failure to Attend an IME.

If the worker fails to attend an IME and does not notify the insurer before the date of the IME or does not have sufficient reason for not attending the IME, the director may impose a monetary penalty against the worker for failure to attend.

(11) IME Report.

(a) After the IME is complete, the IME provider must send the insurer a report that includes, but is not limited to the following:

(A) Clear and accurate documentation of all tests performed;

(B) Who performed the IME;

(C) Who dictated the report;

(D) A signed quality assurance statement acknowledging that to the best of the IME provider's ability all statements contained in the report are true and accurate; and

(E) A copy of the observer [Form 3923A](#), the invasive procedure [Form 3227](#), or both, if applicable.

(b) The IME provider must communicate with the insurer if the IME provider is unable to provide the report within the insurer's requested time period and provide a date when the report will be sent.

(c) The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within three business days of the insurer's receipt of the report.

(12) Request for Additional IME.

(a) When the insurer has obtained the three IMEs allowed under section (1) of this rule, the insurer must request authorization from the director before scheduling the worker for an additional IME. An insurer that fails to request authorization from the director may be assessed a civil penalty.

(b) The insurer must submit a request for authorization to the director for an additional IME by using [Form 2333](#), "Insurer's Request for Director Approval of an Additional Independent Medical Examination." The insurer must send a copy of the request to the worker and the worker's attorney, if represented.

(c) The director will review the request and determine if additional information from the insurer or the worker is needed.

(A) Upon receiving a written request for additional information from the director, the parties have 14 days to respond.

(B) If the parties do not provide the requested information within the timeframes in paragraph (A), the director will issue an order approving or disapproving the request based on available information.

(d) The director, when making a determination to approve or deny the request for an additional IME, will consider, but is not limited to, whether:

(A) An IME involving the same disciplines or review of the same condition has been completed within the past six months;

(B) There has been a significant change in the worker's condition;

(C) There is a new condition or compensable aspect in the claim;

(D) There is a conflict of medical opinions about a worker's medical treatment, medical services, impairment, stationary status, or other issues critical to claim processing or benefits;

(E) The IME is requested to establish a preponderance for medically stationary status;

(F) The IME is medically harmful to the worker, and

(G) The IME is requested for a condition for which the worker has sought treatment or services, or the condition has been included in the compensable claim.

(e) Any party that disagrees with the director's order to approve or disapprove a request for an additional IME may request a hearing by the board under ORS 656.283 and OAR chapter 438.

(13) Other Exams – Not Considered IMEs.

The following exams are not considered IMEs and do not require approval as outlined in section (12) of this rule:

(a) An exam, including a closing exam, requested by the worker's attending physician or authorized nurse practitioner;

(b) An exam requested by the director;

(c) An elective surgery consultation requested under OAR 436-010-0250(2)(b);

(d) An exam of a permanently totally disabled worker required under ORS 656.206(5);

(e) A closing exam that has been arranged by the insurer at the attending physician's or authorized nurse practitioner's request; and

(f) An exam requested by the managed care organization (MCO) for the purpose of clarifying or refining a plan for continuing medical services as provided under the MCO's contract.

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264

Hist: Amended 6/13/22 as Admin. Order 22-054, eff. 7/1/22

436-010-0270 Insurer's Rights and Duties

(1) Notifications.

(a) Immediately following receipt of notice or knowledge of a claim, the insurer must notify the worker in writing about how to receive medical services for compensable injuries.

(b) Within 10 days of any change in the status of a claim, (e.g., acceptance or denial of a claim, or a new or omitted medical condition), the insurer must notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any.

(c) In disabling and nondisabling claims, immediately following notice or knowledge that the worker is medically stationary, the insurer must notify the worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).

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(d) When the insurer establishes a medically stationary date that is not based on the findings of an attending physician or authorized nurse practitioner, the insurer must notify all medical service providers of the worker's medically stationary status. For all injuries occurring on or after October 23, 1999, the insurer must pay all medical service providers for services rendered until the insurer provides notice of the medically stationary date to the attending physician or authorized nurse practitioner.

(2) Medical Records Requests.

(a) Insurers may request relevant medical records, using [Form 2476](#), "Request for Release of Medical Records for Oregon Workers' Compensation Claim," or a computer-generated equivalent of Form 2476, with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

(b) Within 14 days of receiving a request, the insurer must forward all relevant medical information to return-to-work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner.

(3) **Pre-authorization.** Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request for preauthorization of diagnostic imaging studies, other than plain film X-rays. The response must include whether the service is pre-authorized or not pre-authorized.

(4) Communication with Providers.

(a) The insurer or its representative must respond to a medical provider's inquiry about claim status, accepted conditions, or MCO enrollment within two days, excluding Saturdays, Sundays, and legal holidays listed in ORS 187.010 and 187.020. The insurer or its representative may not refer the medical provider to another entity to obtain an answer.

(b) An insurer or its representative and a medical provider may agree to communicate about claim status, accepted conditions, or MCO enrollment by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Information Protection Act under ORS 646A.600 to 646A.628 and federal law.

(5) Insurer's Duties under MCO Contracts.

(a) Insurers who enter into an MCO contract under OAR 436-015, must notify the affected employers of the following:

(A) The names and addresses of all MCO panel providers within the employer's geographical service area(s);

(B) How workers can receive compensable medical services within the MCO;

(C) How workers can receive compensable medical services by non-panel providers; and

(D) The geographical service area governed by the MCO.

(b) Insurers under contract with an MCO must notify any newly insured employers as specified in subsection (4)(a) of this rule no later than the effective date of coverage.

(c) When the insurer is enrolling a worker in an MCO, the insurer must provide the name, address, and telephone number

of the worker and, if represented, the worker's attorney's name, mailing address, phone number, and, if known, fax number and email address to the MCO.

(d) When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical providers, and the MCO of enrollment. To be considered complete, the notice must:

(A) Provide the worker a written list of the eligible attending physicians within the relevant MCO geographic service area or provide a Web address to access the list of eligible attending physicians. If the notice does not include a written list, then the notice must also:

(i) Provide a telephone number the worker may call to ask for a written list; and

(ii) Tell the worker that they have seven days from the mailing date of the notice to request the list;

(B) Explain how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

(C) Advise the worker how to obtain medical services for compensable injuries within the MCO. This includes whether the worker:

(i) Must change attending physician or authorized nurse practitioner to an MCO panel provider, or

(ii) May continue to treat with the worker's current attending physician or authorized nurse practitioner;

(D) Explain how the worker can receive compensable medical treatment from a "come-along" provider;

(E) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer, except when the employer provides a coordinated health care program. For the purpose of this rule, "coordinated health care program" means an employer program providing coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides the workers with health care benefits even if a workers' compensation claim is denied; and

(F) Notify the worker of the worker's right to appeal MCO decisions and provide the worker with the title, address, and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes.

(e) When an insurer enrolls a worker in an MCO before claim acceptance, the insurer must inform the worker in writing that the insurer will pay for certain medical services even if the claim is denied. Necessary and reasonable medical services that are not otherwise covered by health insurance will be paid until the worker receives the notice of claim denial or until three days after the denial is mailed, whichever occurs first.

(f) When a worker who is not yet medically stationary must change medical providers because an insurer enrolled the worker in an MCO, the insurer must notify the worker of the right to request review before the MCO if the worker believes the change would be medically detrimental.

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(g) The insurer may delegate to the MCO responsibility for issuing the enrollment notice required by ORS 656.245(4)(a) and these rules by express provision in the contract between those parties; however, the insurer remains liable for any deficiencies in the notice issued by the MCO.

(h) If, at the time of MCO enrollment, the worker's medical service providers are not members of the MCO and do not qualify as "come-along providers," the insurer must notify the worker and providers regarding provisions of care under the MCO contract, including continuity of care as provided by OAR 436-015-0037(3).

(i) Within seven days of receiving a dispute regarding an issue that should be processed through the MCO dispute resolution process and a copy has not been sent to the MCO, the insurer must:

(A) Send a copy of the dispute to the MCO; or

(B) If the MCO does not have a dispute resolution process for that issue, notify the parties in writing to seek administrative review before the director.

(j) The insurer must notify the MCO within seven days of receiving notification of the following:

(A) When the worker obtains representation by an attorney, the attorney's name, mailing address, phone number, and, if known, fax number and email address;

(B) Any changes to the worker's or worker's attorney's name, address, or telephone number;

(C) Any requests for medical services from the worker or the worker's medical provider; or

(D) Any request by the worker to continue treating with a "come-along" provider.

(k) When an MCO pre-certifies a surgical service as medically appropriate, the insurer must, within 45 days from the mailing date of the MCO decision, notify the worker, the worker's representative, the provider, and the MCO whether the insurer approves the surgery.

(A) If the insurer disapproves the surgery for reasons other than appropriateness or whether the surgery is excessive or ineffectual, the disapproval must include the following notice in bold text and be formatted as follows:

Notice to worker, worker's attorney, and medical provider:

If you want to appeal this decision, you must do so within 90 days from the mailing date of this notice. To appeal you must:

- **Notify the Department of Consumer and Business Services (DCBS) in writing.**
- **Send your written request for review of the insurer's disapproval to:**

**DCBS Workers' Compensation Division
Medical Resolution Team**

**350 Winter Street NE
PO Box 14480
Salem OR 97309-0405**

If you do not notify DCBS in writing within 90 days, you will lose all rights to appeal the insurer's decision.

For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.

(B) If the insurer disagrees with the appropriateness decision of the MCO, the insurer must appeal the decision to the MCO under OAR 436-015-0110(4).

(I) Insurers under contract with MCOs must maintain records including, but not limited to:

(A) A listing of all employers covered by MCO contracts;

(B) The employers' WCD employer numbers;

(C) The estimated number of employees governed by each MCO contract;

(D) A list of all workers enrolled in the MCO; and

(E) The effective dates of such enrollments.

(m) When the insurer is disenrolling a worker from an MCO, the insurer must simultaneously provide written notice of the disenrollment to the worker, the worker's representative, all medical service providers, and the MCO. The insurer must mail the notice no later than seven days before the date the worker is no longer subject to the contract. The notice must tell the worker how to obtain compensable medical services after disenrollment.

(n) When an MCO contract expires or is terminated without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days before the date the contract expires or terminates. The notice must tell the worker how to obtain compensable medical services after the worker is no longer subject to the MCO contract.

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264

Hist: Amended 3/5/24 as Admin. Order 24-051, eff. 4/1/24

Amended 3/11/25 as Admin. Order 24-051, eff. 4/1/25

436-010-0280 Determination of Impairment / Closing Exams

(1) When a worker becomes medically stationary and there is a reasonable expectation of permanent disability, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. If the worker is under the care of an authorized nurse practitioner, physician associate, or a naturopathic physician, the provider must refer the worker to a type A attending physician to do a closing exam.

(2) The closing exam must be completed under OAR 436-030 and 436-035 and [Bulletin 239](#). (See Appendix A "Matrix for Health Care Provider Types".)

(3) When the attending physician completes the closing exam, the attending physician has 14 days from the medically stationary date to send the closing report to the insurer. When the attending physician does not complete the closing exam, the attending physician must arrange, or ask the insurer to arrange, a closing exam with a consulting physician within seven days of the medically stationary date.

(4) When an attending physician or authorized nurse practitioner requests a consulting physician to do the closing exam, the consulting physician has seven days from the date of the exam to send the report to the attending physician for concurrence or objections. Within seven days of receiving the closing exam report, the attending physician must state in writing whether the physician concurs with or objects to all or part of the findings of the exam, and send the concurrence or objections with the report to the insurer.

(5) The attending physician must specify the worker's residual functional capacity if:

(a) The attending physician has not released the worker to the job held at the time of injury because of a permanent work restriction caused by the compensable injury, and

(b) The worker has not returned to the job held at the time of injury, because of a permanent work restriction caused by the compensable injury.

(6) Instead of specifying the worker's residual functional capacity under section (5) of this rule, the attending physician may refer the worker for:

(a) A second-level physical capacities evaluation (see OAR 436-009-0060) when the worker has not been released to return to the job held at the time of injury, has not returned to the job held at the time of injury, has returned to modified work, or has refused an offer of modified work; or

(b) A work capacities evaluation (see OAR 436-009-0060) when there is a question of the worker's ability to return to suitable and gainful employment. The provider may also be required to specify the worker's ability to perform specific job tasks.

(7) When the insurer issues a major contributing cause denial on an accepted claim and the worker is not medically stationary:

(a) The attending physician must do a closing exam or refer the worker to a consulting physician for all or part of the closing exam; or

(b) An authorized nurse practitioner, physician associate, or naturopathic physician must refer the worker to a type A attending physician for a closing exam.

(8) The closing report must include all of the following:

(a) Findings of permanent impairment.

(A) In an initial injury claim, the closing report must include objective findings of any permanent impairment that is caused

in any part by an accepted condition or a direct medical sequela of an accepted condition.

(B) In a new or omitted condition claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(C) In an aggravation claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(D) In an occupational disease claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(b) Findings documenting permanent work restrictions.

(A) If the worker has no permanent work restriction, the closing report must include a statement indicating that:

(i) The worker has no permanent work restriction; or

(ii) The worker is released, without restriction, to the job held at the time of injury.

(B) In an initial injury claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted condition or a direct medical sequela of an accepted condition.

(C) In a new or omitted condition claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(D) In an aggravation claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(E) In an occupational disease claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted occupational disease or a direct medical sequel of an accepted occupational disease.

(c) A statement regarding the validity of an impairment finding is required in the following circumstances:

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(A) If the examining physician determines that a finding of impairment is invalid, the closing report must include a statement that identifies the basis for the determination that the finding is invalid.

(B) If the examining physician determines that a finding of impairment is valid but the finding is not addressed by any applicable validity criteria under [Bulletin 239](#), the closing report must include a statement that identifies the basis for the determination that the finding is valid.

(C) If the examining physician chooses to disregard applicable validity criteria under Bulletin 239 because the criteria are medically inappropriate for the worker, the closing report must include a statement that describes why the criteria would be inappropriate.

Stat. Auth: ORS 656.726(4), 656.245(2)(b)

Stats. Implemented: ORS 656.245, 656.252

Hist: Amended 3/13/18 as Admin. Order 18-054, eff. 4/1/18

Amended 11/22/23 as Admin. Order 23-055, eff. 1/1/2024

SMC (physician assistant name change) ORS 183.335(7), (WCD 9-2024) eff. 6/6/24

436-010-0290 Medical Care After Medically Stationary

(1) A worker is found medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. Medical services after a worker's condition is medically stationary are compensable only when services are:

- (a) Palliative care under section (2) of this rule;
- (b) Curative care under sections (3) and (4) of this rule;
- (c) Provided to a worker who has been determined permanently and totally disabled;
- (d) Prescription medications;
- (e) Necessary to administer or monitor administration of prescription medications;
- (f) Prosthetic devices, braces, or supports;
- (g) To monitor the status of, to replace, or to repair prosthetic devices, braces, and supports;
- (h) Provided under an accepted claim for aggravation;
- (i) Provided under Board's Own Motion;
- (j) Necessary to diagnose the worker's condition; or
- (k) Life-preserving modalities similar to insulin therapy, dialysis, and transfusions.

(2) Palliative Care.

(a) Palliative care means that medical services are provided to temporarily reduce or moderate the intensity of an otherwise stable medical condition. It does not include those medical services provided to diagnose, heal, or permanently alleviate or eliminate a medical condition. Palliative care is compensable when the attending physician prescribes it and it is necessary to enable the worker to continue current employment or a vocational training program. Before palliative care can begin, the attending physician must submit a written palliative care request to the insurer for approval. The request must:

- (A) Describe any objective findings;
- (B) Identify the medical condition for which palliative care is requested by the appropriate ICD diagnosis;

(C) Detail a treatment plan which includes the name of the provider who will provide the care, specific treatment modalities, and frequency and duration of the care, not to exceed 180 days;

(D) Explain how the requested care is related to the compensable condition; and

(E) Describe how the requested care will enable the worker to continue current employment, or a current vocational training program, and the possible adverse effect if the care is not approved.

(b) Palliative care may begin after the attending physician submits the request to the insurer. If the insurer approves the request, palliative care services are payable from the date service begins. However, if the request is ultimately disapproved, the insurer is not liable for payment of the palliative care services.

(c) Insurers must date stamp all palliative care requests upon receipt. Within 30 days of receiving the request, the insurer must send written notice approving or disapproving the request to the attending physician, the provider who will provide the care, the worker, and the worker's attorney. If the request is disapproved, the notice must include the following in bold text and be formatted as follows:

Notice to worker, worker's attorney, and attending physician:

If you want to appeal this decision, you must do so within 90 days from the mailing date of this notice. To appeal you must:

- Notify the Department of Consumer and Business Services (DCBS) in writing.**
- Send your written request for review to:**

**DCBS Workers' Compensation Division
Medical Resolution Team
350 Winter Street NE
PO Box 14480
Salem OR 97309-0405**

If you do not notify DCBS in writing within 90 days, you will lose all rights to appeal the decision.

For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.

(d) If the insurer disapproves the request, the insurer must explain the reason why in writing. Reasons to disapprove a palliative care request may include:

- (A) The palliative care services are not related to the compensable conditions;

(B) The palliative care services are excessive, inappropriate, or ineffectual; or

(C) The palliative care services will not enable the worker to continue current employment or a current vocational training program.

(e) When the insurer disapproves the palliative care request, the attending physician or the worker may request administrative review before the director under OAR 436-010-0008. The request for review must be within 90 days from the date of the insurer's disapproval notice. In addition to information required by OAR 436-010-0008, if the request is from the attending physician, it must include:

(A) A copy of the original request to the insurer; and

(B) A copy of the insurer's response.

(f) If the insurer fails to respond to the request in writing within 30 days, the attending physician or worker may request approval from the director within 120 days from the date the request was first submitted to the insurer. When the attending physician requests approval from the director, the physician must include a copy of the original request and may include any other supporting information.

(g) Subsequent requests for palliative care are subject to the same process as the initial request; however, the insurer may waive the requirement that the attending physician submit a supplemental palliative care request.

(3) Curative Care.

Curative medical care is compensable when the care is provided to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition.

(4) Advances in Medical Science.

The director must approve curative care arising from a generally recognized, nonexperimental advance in medical science since the worker's claim was closed that is highly likely to improve the worker's condition and that is otherwise justified by the circumstances of the claim. When the attending physician believes that curative care is appropriate, the physician must submit a written request for approval to the director. The request must:

(a) Describe any objective findings;

(b) Identify the appropriate ICD diagnosis (the medical condition for which the care is requested);

(c) Describe in detail the advance in medical science that has occurred since the worker's claim was closed that is highly likely to improve the worker's condition;

(d) Provide an explanation, based on sound medical principles, as to how and why the care will improve the worker's condition; and

(e) Describe why the care is otherwise justified by the circumstances of the claim.

Stat. Auth: ORS 656.726

Stats. Implemented: ORS 656.245

Hist: Amended 3/5/24 as Admin. Order 24-051, eff. 4/1/24

Amended 3/11/25 as Admin. Order 24-051, eff. 4/1/25

436-010-0300 Requesting Exclusion of Medical Treatment from Compensability

If a worker or insurer believes that any medical treatment is unscientific, unproven as to its effectiveness, outmoded, or experimental, either party may initiate a request for exclusion of the medical treatment from compensability under ORS 656.245(3). The request must include documentation on why the medical treatment should be excluded from compensability for workers' compensation claims. The director will request advice from the licensing boards of practitioners that might be affected and the Medical Advisory Committee. The director will issue an order and may adopt a rule declaring the treatment to be noncompensable. The decision of the director is appealable under ORS 656.704. Request for administrative review of an individual worker's treatment under ORS 656.327 does not initiate review under this process. Excluded treatments are listed in OAR 436-009-0010.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245

Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

436-010-0330 Medical Arbiters and Physician Reviewers

(1) The director will establish and maintain a list of arbiters. The director will appoint a medical arbiter or a panel of medical arbiters from this list under ORS 656.268.

(2) The director will establish and maintain a list of physician reviewers. The director will appoint an appropriate physician or a panel of physicians from this list to review medical treatment or medical services disputes under ORS 656.245 and 656.327.

(3) When a worker is required to attend an examination under this rule, the director will provide notice of the examination to the worker and all affected parties. The notice will inform all parties of the time, date, location, and purpose of the examination. Examinations will be at a place reasonably convenient to the worker, if possible.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.268, 656.325, 656.327

Hist: Amended 3/7/16 as Admin. Order 16-051, eff. 4/1/16

436-010-0335 Monitoring and Auditing Medical Providers

(1) The director may monitor and conduct periodic audits of medical providers to ensure compliance with ORS chapter 656 and chapter 436 of the administrative rules.

(2) All records maintained or required to be maintained must be disclosed upon request of the director.

Stat. Auth: ORS 656.726(4); Stat. Implemented: ORS 656.245, 656.254, 656.745

Hist: Amended and renumbered from OAR 436-010-0260 8/20/15 as Admin. Order 15-060, eff. 10/1/15

436-010-0340 Sanctions and Civil Penalties

(1) If the director finds any medical provider in violation of the medical reporting requirements established under ORS 656.245, 656.252, 656.254, or 656.325, or OAR 436-009 or 436-010, the director may impose one or more of the following sanctions:

(a) Reprimand by the director;

(b) Nonpayment, reduction, or recovery of fees in part or whole for medical services provided;

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(c) Referral to the appropriate licensing board;
(d) Civil penalty not to exceed \$1,000 for each occurrence. In determining the amount of penalty to be assessed, the director will consider:

- (A) The degree of harm inflicted on the worker or the insurer;
- (B) Whether there have been previous violations; and
- (C) Whether there is evidence of willful violations; or

(e) A penalty of \$100 for each violation of ORS 656.325(1)(c)(C).

(2) If the medical provider fails to provide information under OAR 436-010-0240 within 14 days of receiving a request sent by certified mail or fax, penalties under this rule or OAR 436-015-0120 may be imposed.

(3) The director may impose a penalty of forfeiture of fees and a fine not to exceed \$1,000 for each occurrence on any medical service provider who, under ORS 656.254, and 656.327, has been found to:

- (a) Fail to comply with the medical rules;
- (b) Provide medical services that are excessive, inappropriate, or ineffectual; or
- (c) Engage in any conduct demonstrated to be dangerous to the health or safety of a worker.

(4) If the conduct as described in section (3) of this rule is found to be repeated and willful, the director may declare the medical provider ineligible for reimbursement for treating workers' compensation patients for a period not to exceed three years.

(5) A medical provider whose license has been suspended or revoked by the licensing board for violations of professional ethical standards may be declared ineligible for reimbursement for treating workers' compensation patients for a period not to exceed three years. A certified copy of the revocation or suspension order will be prima facie justification for the director's order.

(6) If a financial penalty is imposed on the medical provider for violation of these rules, the provider may not seek recovery of the penalty fees from the worker.

(7) If an insurer or worker believes sanctions under sections (1) or (2) of this rule are appropriate, either may submit a complaint in writing to the director.

(8) If the director finds an insurer in violation of the notification provisions of OAR 436-010 limiting medical services, the director may order the insurer to reimburse any affected medical providers for services provided until the insurer complies with the notification requirement.

(9) The director may assess a civil penalty under ORS 656.745(2) against an insurer that violates ORS chapter 656, OAR 436-009, OAR 436-010, or an order of the director.

(10) The director may impose a \$100 penalty per occurrence under ORS 656.325 against a worker who fails to meet the requirements in OAR 436-010-0265(10), to be deducted from future benefits..

Stat. Auth: ORS 656.726(4); Stat. Implemented: ORS 656.245, 656.254, 656.745
Hist: Amended 12/17/19 as Admin. Order 19-061, eff. 1/1/20

Appendix A - Matrix for health care provider types *

See 436-010-0210

	Attending physician status (primarily responsible for treatment of a patient)	Provides compensable medical services for initial injury or illness	Authorizes payment of temporary disability and releases the patient to work	Establishes impairment findings (permanent disability)	Provides compensable medical services for aggravation of injury or illness
Type A attending physician Medical doctor Doctor of osteopathic medicine Oral and maxillofacial surgeon Podiatric physician and surgeon	Yes	Yes	Yes	Yes	Yes
Type B attending physician Chiropractic physician Naturopathic physician	Yes, for a total of 60 consecutive days or 18 visits, from the date of the first visit on the initial claim with any Type B attending physician.	Yes, unless the total of 60 consecutive days or 18 visits from the date of the first visit on the initial claim with any Type B attending physician has passed. Or, if authorized by an attending physician and under a treatment plan.	Yes, 30 days from the date of the first visit with any type B attending physician on the initial claim, if within the specified 18 visit period.	No, unless the type B attending physician is a chiropractic physician.	No, unless authorized by a type A attending physician and under a written treatment plan.
Type C attending physician Physician Associate	Yes, for a total of 180 consecutive days from the date of the first visit on the initial claim with any physician associate.	Yes, for 180 consecutive days from the date of the first visit to any physician associate on the initial claim. Or, if authorized by an attending physician.	Yes, for 180 days from the date of the first visit with any physician associate on the initial claim.	No.	No, unless authorized by a type A attending physician.
Authorized nurse practitioner	No	Yes, for 180 consecutive days from the date of the first visit to any authorized nurse practitioner on the initial claim. Or, if authorized by attending physician.	Yes, for 180 days from the date of the first visit with any authorized nurse practitioner on the initial claim.	No	No, unless authorized by a type A attending physician.
Emergency room physician	No, if the physician refers the patient to a primary care physician.	Yes	An ER physician who is not authorized to serve as attending physician under ORS 656.005(12)(c) may authorize temporary disability for up to 14 days, including retroactive authorization.	No, if patient referred to a primary care physician.	Yes

	Attending physician status (primarily responsible for treatment of a patient)	Provides compensable medical services for initial injury or illness	Authorizes payment of temporary disability and releases the patient to work	Establishes impairment findings (permanent disability)	Provides compensable medical services for aggravation of injury or illness
"Other Health Care Providers" e.g., acupuncturists	No	Yes, for 30 consecutive days or 12 visits from the date of the first visit on the initial claim with any "Other Health Care Providers." Thereafter, services must be provided under a treatment plan and authorized by the attending physician.	No	No	"Other Health Care Providers" e.g., acupuncturists

* This matrix does not apply to Managed Care Organizations

**Independent Medical Examination (IME)
Requirements and Standards of Professional Conduct**

Appendix B

- 1. IME providers must maintain effective communication, which includes but is not limited to:**
 - a. Taking steps to avoid personal conflicts during the IME and to the extent they arise, an IME provider must be prepared to address the conflict in a professional and constructive manner and adapt to situations by changing strategy or communication style when appropriate.
 - b. Maintaining the confidentiality of the parties involved in the exam subject to applicable laws.
 - c. Allowing the worker to express themselves fully without unnecessary interruption. If the IME provider needs more information after a worker has answered a question, the IME provider must rephrase the question and explain why they are asking again.
- 2. IME providers must conduct an objective and impartial examination, which includes but is not limited to:**
 - a. Conducting the IME without any preconceived notions or premature conclusions.
 - b. Not sharing personal feelings or personal opinions.
 - c. Remaining objective and impartial, both in reporting and during the examination.
 - d. Basing findings and opinions only on established medical fact, practice, and theory, and not on an accepted fee for services.
 - e. Recusing themselves prior to the IME if there is any sort of pre-existing conflict, whether apparent or actual.
 - f. Being fair, truthful, and forthright in interactions with the worker and insurers whether through written documentation or oral communication.
- 3. IME providers must maintain dignity and respect for the parties involved, which includes but is not limited to:**
 - a. Treating the worker with dignity and respect and listening attentively.
 - b. Giving the worker appropriate empathy for pain, discomfort, and anxiety.
 - c. Using an appropriate tone and being aware of the worker's demeanor and body language when conducting the IME.
 - d. Being courteous and polite to the worker.
 - e. Being respectful of the worker's scheduled time for the IME and minimizing the necessary preparation for the IME while the worker waits.
 - f. Refraining from making disparaging or insulting comments to the worker about any party to the claim.
 - g. Refraining from criticizing or degrading the worker about their behavior or the history they provide.
 - h. Respecting a worker's answer of no, if the IME provider asks for permission to allow someone other than a scribe or chaperone to sit in on the IME without further questioning or encouraging a worker to provide permission.
- 4. Before the IME starts, the IME provider must:**
 - a. Identify themselves to the worker as an IME provider;
 - b. Verify the worker's identity;
 - c. Tell the worker who requested the IME;
 - d. Tell the worker that an ongoing physician-patient relationship will not be sought or established;
 - e. Tell the worker that any information provided during the IME will be documented in a report;
 - f. Let the worker know that the IME provider cannot share opinions with them but will document findings in the report;
 - g. Explain the procedures that will be used during the IME;
 - h. Tell the worker that they may terminate a procedure if the worker feels the activity is beyond the worker's physical capacity or when pain occurs; and
 - i. Ask the worker if they have any questions about the IME process.
- 5. During the IME, the IME provider must:**
 - a. Ensure the worker has privacy to disrobe;
 - b. Sufficiently examine the conditions being evaluated to answer the requesting party's questions; and
 - c. Let the worker know when the exam has concluded, and ask if the worker wants to provide more information or has questions.

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 015

MANAGED CARE ORGANIZATIONS

Effective April 1, 2025

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436-015-0001 Purpose and Applicability of These Rules

(1) Purpose.

The purpose of these rules is to establish and provide policies, procedures, and requirements to administer, evaluate, and enforce statutes relating to the delivery of medical services by managed care organizations (MCOs) to workers within the workers' compensation system.

(2) Applicability of Rules.

(a) These rules apply on and after the effective date and govern all MCOs and insurers contracting with an MCO.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(c) Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.

(3) Timeliness of Documents.

Timeliness of any document required by these rules to be filed with or submitted to the division is determined as follows:

(a) If a document is mailed, it will be considered filed on the date it is postmarked.

(b) If a document is faxed or emailed, it must be received by the division by 11:59 p.m. Pacific Time to be considered filed on that date.

(c) If a document is delivered, it must be delivered during regular business hours to be considered filed on that date.

(d) The date and time of receipt for electronic filings is determined under ORS 84.043.

(e) Time periods allowed for a filing or submission to the division are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.260

Hist: Amended 3/3/21, as Admin. Order 21-053, eff. 4/1/21

436-015-0005 Definitions

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 and OAR 436-010-0005 are hereby incorporated by reference and made a part of these rules.

(1) **"Administrative review"** means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001.

(2) **"Come-along provider"** means a primary care physician, a chiropractic physician, physician associate, or an authorized nurse practitioner who is not a managed care organization (MCO) panel provider and who is authorized to continue to treat the worker when the worker becomes enrolled in an MCO.

(3) **"Coordinated health care program"** means an employer program providing for the coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides workers with health care benefits even if a workers' compensation claim is denied.

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

(5) **"Geographic service area (GSA)"** means an area of the state in which a managed care organization may be authorized by the director of the Department of Consumer and Business Services to provide managed care services. There are 15 geographic service areas in Oregon.

(6) **"Good cause"** means circumstances that are outside the control of a party or circumstances that are considered to be extenuating by the division.

(7) **"Group of medical service providers"** means individuals duly licensed to practice one or more of the healing arts who join together to provide medical services through a managed care organization, whether or not such providers have an ownership interest in the managed care organization.

(8) **"Health care provider"** means an entity or group of entities, organized to provide health care services or to provide

administrative support services to entities providing health care services. An entity solely organized to become an MCO under these rules is not, in and of itself, a health care provider.

(9) **"Insurer"** means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in the state; or an employer or employer group that has been certified under ORS 656.430 and meets the qualifications of a self-insured employer under ORS 656.407.

(10) **"Managed care organization" ("MCO")** means an organization formed to provide medical services and certified under these rules.

(11) **"Medical provider"** means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.

(12) **"Medical service"** means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulance, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports, and, where necessary, physical restorative services.

(13) **"Medical service provider"** means a person duly licensed to practice one or more of the healing arts.

(14) **"Non-qualifying employer"** means either:

(a) An insurer as defined in this rule, with respect to managed care services to be provided to any subject worker; or

(b) An employer as defined under ORS 656.005(13), other than a health care provider, with respect to managed care services to such employer's employees.

(15) **"Primary care physician"** means a physician qualified to be an attending physician according to ORS 656.005(12)(b)(A) and who is a general practitioner, family practitioner, or internal medicine practitioner.

(16) **"Show-cause hearing"** means an informal meeting with the director or the director's designee where the MCO is provided an opportunity to explain and present evidence regarding any proposed orders by the director to suspend or revoke the MCO's certification.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.260

Hist: Amended 3/11/19 as Admin. Order 19-053, eff. 4/1/19

SMC (physician assistant name change) ORS 183.335(7), (WCD 10-2024) eff. 6/6/24

436-015-0007 Entities Allowed to Manage Care

(1) Only an MCO may provide managed care services as described in ORS 656.260(4)(d) and (21)(a), except as allowed under OAR 436-015-0009.

(2) An insurer or someone acting on behalf of an insurer may not manage the care of workers by limiting the choice of medical providers, or by requiring medical providers to abide by specific treatment standards, treatment guidelines, or treatment protocols.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.260

Hist: Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18

Amended 11/22/23 as Admin. Order 23-056, eff. 1/1/2024

436-015-0008 Request for Review before the Director

(1) The process for administrative review is as follows:

(a) Any party that disagrees with an action of an MCO must first use the MCO's dispute resolution process. If the party does not appeal the MCO's decision, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision unless the party can show good cause. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision.

When a party mistakenly sends an appeal of an MCO action or decision to the division, the division will forward the appeal to the MCO. The MCO must use the original mailing date of the appeal mistakenly sent to the division when determining timeliness of the appeal.

(b) Within 60 days of the date the MCO issues a final decision under the MCO's dispute resolution process, the aggrieved party must file a written request for administrative review with the division. The request must specify the grounds upon which the action is contested.

If a party has been denied access to an MCO dispute resolution process because the complaint or dispute was not included in the MCO's dispute resolution process or because the MCO's dispute resolution process was not completed for reasons beyond a party's control, the party must request administrative review within 60 days of the failure of the MCO to issue a decision.

When the aggrieved party is a represented worker, and the worker's attorney had given written notice of representation to the insurer at the time the MCO issued its decision, the 60-day time frame begins when the MCO issues its final decision to the attorney.

(c) The director will create a documentary record sufficient for judicial review. The director may require and allow the parties to submit input and information appropriate to complete the review.

(d) The director will review the record and issue an order. The order must specify that it will become final within 30 days of the mailing date of the order unless a written request for hearing is filed with the division.

(2) Dispute Resolution by Agreement.

Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed. When a dispute is resolved by agreement of the parties to the director's satisfaction, the agreement must be in writing and approved by the director. If the dispute does not resolve through mediation, administrative review will continue.

(3) Physician Review (e.g., appropriateness).

If the director determines an evaluation by a physician is indicated to resolve the dispute, the director may appoint an appropriate medical service provider or panel of providers under ORS 656.325(1) to review the medical records and, if necessary, examine the worker and perform any necessary and

reasonable medical tests, other than invasive tests. The worker may refuse an invasive test without sanction.

(a) A single physician selected to conduct an evaluation must be a practitioner of the same healing art and specialty, if practicable, as the medical service provider whose treatment or service is being reviewed.

(b) When a panel of physicians is selected, at least one panel member must be a practitioner of the same healing art and specialty, if practicable, as the medical service provider whose treatment or service is being reviewed.

(c) When an examination of the worker is required, the director will notify the appropriate parties of the date, time, and location of the examination. No party may directly contact the physician or panel except as it relates to the examination date, time, location, and attendance. If the parties want the physician or panel to address specific questions, the parties must submit these questions to the director for screening. The director will determine the appropriateness of the questions. Matters not related to the issues before the director are inappropriate for medical evaluation, and the director will not submit questions regarding such matters to the evaluating physician(s). The evaluation may include:

(A) A review of all medical records and diagnostic tests submitted;

(B) An examination of the worker; and

(C) Any necessary and reasonable medical tests.

(4) Hearings.

Except as provided in sections (5) and (6), any party that disagrees with an order under these rules may file a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order. OAR 436-001 applies to the hearing. In the review of orders issued under ORS 656.260(15) and (16), no new medical evidence or issues will be admitted at hearing. In these reviews, administrative orders may be modified at hearing only if the administrative order is not supported by substantial evidence in the record or reflects an error of law. The dispute may be remanded to the MCO for further evidence taking, correction, or other necessary action if the administrative law judge or director determines the record has been improperly, incompletely, or otherwise insufficiently developed.

(5) Request for Hearing on Proposed Sanctions and Civil Penalties.

Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of civil penalty issued by the director under ORS 656.745, or to a civil penalty or cease and desist order issued under ORS 656.260(21), may request a hearing by the Hearings Division of the Workers' Compensation Board (board) as follows:

(a) The party must file a written request for a hearing with the division within 60 days after the mailing date of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The division will forward the request and other pertinent information to the board.

(c) An administrative law judge from the Hearings Division, acting on behalf of the director, will conduct the hearing under ORS 656.740 and ORS chapter 183.

(6) MCO Certification Suspension or Revocation.

Hearings on the suspension or revocation of an MCO's certification:

(a) At a show-cause hearing on a notice of intent to suspend issued under OAR 436-015-0080(2), the MCO must present evidence regarding why it should be permitted to continue to provide services under these rules.

(A) If the director determines that the acts or omissions of the MCO justify suspension of the MCO's certification, the director may issue an order suspending the MCO for a period of time up to a maximum of one year or may initiate revocation proceedings under OAR 436-015-0080(5). If the director determines that the acts or omissions of the MCO do not justify suspension, the director will issue an order withdrawing the notice.

(B) If the MCO disagrees with the order, the MCO may file a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(C) OAR 436-001 applies to the hearing.

(b) A revocation issued under OAR 436-015-0080(5) becomes effective 10 days after service of such notice upon the MCO unless, within such period of time, the MCO corrects the grounds for revocation to the satisfaction of the director or files a written request for a show cause hearing with the division.

(A) If the MCO requests a hearing, the division will set a date for a show cause hearing and will give the MCO at least 10 days notice of the time and place of the hearing. At hearing, the MCO must show cause why it should be permitted to continue to provide services under these rules.

(B) Within 30 days after the hearing, the director will issue an order affirming or withdrawing the revocation.

(C) If the MCO disagrees with the order, the MCO may file a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(D) OAR 436-001 applies to the hearing.

(c) An emergency revocation issued under OAR 436-015-0080(7) is effective immediately. The MCO may file a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 183.310 thru 550; ORS 656.260, 656.325, 656.704.; and 656.726(4)
Stats. Implemented: ORS 656.260, 656.325, and 656.704
Hist: Amended 3/11/19 as Admin. Order 19-053, eff. 4/1/19
Minor correction under ORS 183.335(7) (WCD 16-2020), filed and eff. 11/30/20

436-015-0009 Formed, Owned, or Operated

(1) The director will not certify an MCO formed, owned, or operated by a non-qualifying employer.

**OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
MANAGED CARE ORGANIZATIONS**

**Administrative
Order No.
25-052**

(2) For purposes of this rule, "staff" means any individual who is an employee of a non-qualifying employer or of any parent or subsidiary entity of a non-qualifying employer.

(3) A non-qualifying employer or any of its staff, or their immediate family, may not:

(a) Directly participate in the formation, certification, or incorporation of the MCO;

(b) Nominate, assume a position as, or act in the role of, a director, officer, agent, or employee of the MCO;

(c) Arrange for, lend, guarantee, or otherwise provide financing for any organizational costs of the MCO;

(d) Arrange for, lend, guarantee, or otherwise provide financial support to the MCO (financial support does not include contracted fees for services rendered by an MCO);

(e) Have any ownership or similar financial interest in or right to payment from the MCO;

(f) Make or exercise any control over business, operational, or policy decisions of the MCO;

(g) Possess or control the ownership of voting securities of the MCO. The director will presume possession or control exists if any person, directly or indirectly, holds the power to vote or holds proxies of any other person representing 10 percent or more of the voting securities of the MCO;

(h) Provide MCO services other than as allowed by section (4) of this rule;

(i) Enter into any contract with the MCO that limits the ability of the MCO to accept business from any other source; or

(j) Direct or interfere with the MCO's delivery of medical and health care services.

(4) Notwithstanding section (3) of this rule, an MCO may contract with an insurer to provide certain managed care services. However, such insurer-provided services must be according to protocols and standards established by the certified MCO plan. The insurer may not provide or participate in the provision of managed care services related to dispute resolution, service utilization review, or physician peer review.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.260

Hist: Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18

436-015-0010 Notice of Intent to Form an MCO

(1) Any health care provider or group of medical service providers initiating an MCO under ORS 656.260 must submit a "Notice of Intent to Form" to the director, by certified mail. [Form 2737](#) may be used for this purpose.

(2) The Notice of Intent to Form must include the following:

(a) The identity of each person who participates in discussions intended to result in the formation of an MCO. If the person is a member of a closely held corporation, the notice must include the identity of the shareholders;

(b) The name, address, and telephone number of a contact person; and

(c) A summary of the information that will be shared in discussions preceding the application for MCO certification.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.260

Hist: Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18

436-015-0030 Applying for Certification

(1) General.

The MCO must establish one place of business in Oregon where it administers the plan and keeps membership and other records as required by OAR 436-015-0050.

(2) An applicant for MCO certification must submit the following to the director:

(a) One copy of the application;

(b) A nonrefundable fee of \$1,500, payable to the Department of Consumer and Business Services, which will be deposited in the Consumer and Business Services Fund;

(c) Affidavits of each person identified in section (3) of this rule, certifying that the individuals have no interest in a non-qualifying employer under OAR 436-015-0009;

(d) An affidavit of an authorized officer or agent of the MCO, certifying that the MCO is financially sound and able to meet all requirements necessary to ensure delivery of services under the plan, and in full satisfaction of the MCO's obligations under ORS 656.260 and OAR 436-015; and

(e) A complete organizational chart.

(3) MCO Application.

The application must include:

(a) The name of the MCO;

(b) The name of each person who will be a director of the MCO;

(c) The name of the person who will be the president of the MCO;

(d) The title and name of the person who will be the day-to-day administrator of the MCO;

(e) The title and name of the person who will be the administrator of the financial affairs of the MCO; and

(f) A proposed plan for the MCO, in which the applicant identifies how the MCO will meet the requirements of ORS 656.260 and these rules.

(4) MCO Plan - General.

The plan must:

(a) Identify the initial GSAs in which the MCO intends to operate (For details regarding GSAs, see http://wcd.oregon.gov/Bulletins/bul_248.pdf);

(b) Describe the reimbursement procedures for all services provided;

(c) Include a process for developing financial incentives directed toward reducing service costs and utilization, without sacrificing quality of service;

(d) Describe how the MCO will provide insurers with information that will inform workers of all choices of medical service providers and how workers can access those providers;

(e) Provide a procedure to identify those providers in the panel provider listings that only accept existing patients as workers'

compensation patients. This procedure is not subject to the timeframe established in subsection (f) of this section;

(f) Provide a procedure for regular, periodic updating of all MCO panel provider listings, with published updates being available electronically no less frequently than every 30 days; and

(g) Include a procedure for timely and accurate reporting to the director of necessary information regarding medical and health care service costs and utilization under OAR 436-015-0040 and OAR 436-009.

(5) MCO Plan – Worker Rights.

The plan must provide a description of the times, places, and manner of providing services adequate to ensure that workers governed by the MCO will be able to:

(a) Access an MCO panel with a minimum of one attending physician within the MCO for every 1,000 workers covered by the plan;

(b) Receive initial treatment by an MCO attending physician or authorized nurse practitioner of the worker's choice within 24 hours of the MCO's knowledge of the need or a request for treatment;

(c) Receive treatment by an MCO attending physician or authorized nurse practitioner of the worker's choice within five working days after the worker received treatment outside the MCO;

(d) Receive information on a 24-hour basis regarding medical services available within the MCO which must include:

(A) The worker's right to receive emergency or urgent care, and

(B) The MCO's regular hours of operation if the worker needs assistance selecting an attending physician or has other questions.

(e) Access medical providers, including attending physicians, within a reasonable distance from the worker's place of employment, considering the normal patterns of travel. For purposes of this rule, 30 miles (one way) in urban areas and 60 miles (one way) in rural areas will be considered a reasonable distance;

(f) Receive treatment by a non-MCO medical service provider when the enrolled worker resides outside the MCO's geographic service area. Such a worker may only select non-MCO providers if they practice closer to the worker's residence than an MCO provider of the same category, and if the provider agrees to the MCO's terms and conditions;

(g) Receive services that meet quality, continuity, and other treatment standards which will provide all medical and health care services in a manner that is timely, effective, and convenient for the worker;

(h) Receive specialized medical services the MCO is not able to provide;

(i) Receive treatment that is consistent with MCO treatment standards and protocols; and

(j) Remain eligible to receive authorized temporary disability benefits up to 14 days after the mailing date of a notice enrolling the worker's claim in an MCO under OAR 436-010-0270(4)(d).

(6) MCO Plan – Choice of Provider.

The plan must provide all of the following:

(a) An adequate number, but not less than three, of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractic physician, dentist, naturopathic physician, optometric physician, osteopathic physician, medical physician, and podiatric physician. The worker also must be able to choose from at least three physical therapists and three psychologists. The plan must meet this section's requirements unless the MCO establishes that there is not an adequate number of providers in a given category able or willing to become members of the MCO.

For categories where the MCO has fewer than three providers within a GSA or the MCO, within 14 days, is unable to provide a list of three providers willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from a provider in each of those categories, consistent with the MCO's treatment and utilization standards. Such providers cannot be required to comply with the terms and conditions regarding services performed by the MCO. These providers are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.

(b) A process that allows workers to select an authorized nurse practitioner. If the MCO has fewer than three authorized nurse practitioners within a GSA or the MCO, within 14 days, is unable to provide a list of three authorized nurse practitioners willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from an authorized nurse practitioner, consistent with the MCO's treatment and utilization standards and ORS 656.245(2)(b)(D). Such authorized nurse practitioners cannot be required to comply with the terms and conditions regarding services performed by the MCO. These authorized nurse practitioners are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.

(c) A process that allows workers to select a physician associate. If the MCO has fewer than three physician associates within a GSA or the MCO, within 14 days, is unable to provide a list of three physician associates willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from a physician associate, consistent with the MCO's treatment and utilization standards and ORS 656.245(2)(b)(D). Such physician associates cannot be required to comply with the terms and conditions regarding services performed by the MCO. These physician associates are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.

(d) A procedure that allows workers to receive compensable medical treatment from a come-along provider authorized under OAR 436-015-0070.

(7) MCO Plan – Provider Agreement.

The plan must include:

(a) A copy of the standard provider agreement used by the MCO when a provider is credentialed as a panel provider. Variations from the standard provider agreement must be identified when the plan is submitted for director approval; and

(b) An initial list of the names, addresses, and specialties of the individuals who will provide services within the MCO. This list must indicate which medical service providers will act as attending physicians in each GSA.

(8) MCO Plan – Monitoring and Reviewing.

The plan must provide adequate methods for monitoring and reviewing contract matters between providers and the MCO to ensure appropriate treatment and to prevent inappropriate or excessive treatment including:

(a) A program of peer review and utilization review including the following:

(A) Pre-admission review of elective admissions to the hospital and elective surgeries;

(B) Individual case management programs, which identify ways to provide appropriate care at a lower cost for cases that are likely to prove very costly;

(C) Physician profile analysis which may include such information as each physician's total charges, number and costs of related services provided, workers' temporary disability, and total number of visits in relation to care provided by other physicians to patients with the same diagnosis. A physician's profile must not be released to anyone outside the MCO without the physician's specific written consent, except that the physician's profile must be released to the director without the necessity of obtaining such consent;

(D) Concurrent review programs that periodically review the care after treatment has begun, to determine if continued care is medically necessary;

(E) Retrospective review programs that examine care after treatment has ended, to determine if the treatment rendered was excessive or inappropriate; and

(F) Second surgical opinion programs that allow workers to obtain the opinion of a second physician when elective surgery is recommended.

(b) A quality assurance program that includes:

(A) A system for monitoring and resolving problems or complaints, including those identified by workers or medical service providers;

(B) Physician peer review, which must be conducted by a group designated by the MCO or the director. The group must include members of the same healing art as the peer-reviewed physician; and

(C) A standardized medical record system.

(c) A program that specifies the criteria for selection and termination of panel providers and the process for peer review. The processes for terminating a panel provider and peer review must provide adequate notice and hearing rights.

(d) A program that meets the requirements of ORS 656.260(4) for monitoring and reviewing other contract matters not covered under peer review, service utilization review, dispute resolution, or quality assurance.

(9) MCO Plan – Dispute Resolution.

The plan must include:

(a) A procedure for internal dispute resolution to resolve complaints by enrolled workers, medical providers, and insurers under OAR 436-015-0110. The internal dispute resolution procedure must include a provision allowing waiver of the 30-day period to appeal a decision to the MCO upon a showing of good cause; and

(b) A description of how the MCO will ensure workers continue to receive appropriate care in a timely, effective, and convenient manner throughout the dispute resolution process.

(10) MCO Plan – Treatment Standards, Protocols, and Guidelines.

The plan must include a summary of the process the MCO uses to develop and review treatment standards, protocols, and guidelines. This summary must describe:

(a) The medical expertise or specialties of the clinicians involved;

(b) The basis for protocols and guidelines;

(c) The criteria the MCO uses in selecting the conditions for which the MCO implements treatment protocols and guidelines;

(d) The criteria the MCO uses to determine when it needs to review or revise its treatment standards, protocols, and guidelines;

(e) How the MCO makes the standards, protocols, and guidelines available to its panel providers and how it notifies them of any changes; and

(f) A process that provides sufficient flexibility to allow treatment outside the standards, protocols, and guidelines if such treatment is supported by persuasive professional medical judgment and reasoning.

(11) MCO Plan – Return to Work and Workplace Safety.

The plan must provide other programs that meet the requirements of ORS 656.260(4), including:

(a) A program involving cooperative efforts by the workers, the employer, the insurer, and the MCO to promote early return to work for enrolled workers; and

(b) A program involving cooperative efforts by the workers, the employer, and the MCO to promote workplace safety and health consultative and other services. The program must:

(A) Identify how the MCO will promote such services;

(B) Describe the method by which the MCO will report to the insurer within 30 days of knowledge of occupational injuries and illnesses involving serious physical harm as defined by

OAR 437-001, occupational injury and illness trends as observed by the MCO, and any observations that indicate an injury or illness was caused by a lack of diligence of the employer;

(C) Describe the method by which the MCO's knowledge of needed loss control services will be communicated to the insurer for determining the need for services as detailed in OAR 437-001;

(D) Include a provision that all notifications to the insurer from the MCO will be considered as a request to the insurer for services as detailed in OAR 437-001; and

(E) Include a provision that the MCO will maintain complete files of all notifications for a period of three years following the date that notification was given by the MCO.

(12) Within 45 days of receipt of all information required for certification, the director will notify the applicant if the certification is approved, the effective date of the certification, and the initial GSA(s) of the MCO. If the certification is denied, the director will provide the applicant with the reason for the denial.

(13) The director will not certify an MCO if the plan does not meet the requirements of these rules.

(14) Communication Liaison.

The MCO must designate an in-state communication liaison(s) to the director and the insurers at the MCO's established in-state location.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.260

Hist: Amended 3/11/19 as Admin. Order 19-053, eff. 4/1/19

Minor correction under ORS 183.335(7) (WCD 17-2020), filed and eff. 11/30/20

Amended 11/22/23 as Admin. Order 23-056, eff. 1/1/2024

Amended 3/5/24 as Admin. Order 24-052, eff. 4/1/2024

SMC (physician assistant name change) ORS 183.335(7), (WCD 11-2024) eff. 6/6/24

436-015-0035 Coverage Responsibility of an MCO

(1) The director will designate an MCO's initial geographic service area (GSA). GSAs are established by postal zip code (See http://wcd.oregon.gov/Bulletins/bul_248.pdf). The MCO may only provide contract services in those GSAs approved by the director. Workers are not subject to an MCO contract unless the director has approved the GSA.

(2) Any expansion of an MCO's service area must be approved by the director. The request for expansion must identify the new GSA and include evidence that the MCO has an adequate provider panel which meets the minimum requirements under OAR 436-015-0030. The director may approve the MCO's new GSA without the minimum categories of medical service providers when the MCO establishes that there are not an adequate number of providers in a given category able or willing to become members of the MCO.

For categories where the MCO has fewer than three providers, the MCO must allow workers to seek treatment outside the MCO from providers in those categories. Treatment provided to workers must be consistent with the MCO's treatment and utilization standards. Such providers, unlike come-along providers, cannot be required to comply with the terms and conditions regarding services performed by members of the

MCO. However, while such providers are not themselves bound by the MCO's treatment and utilization standards, workers are subject to those standards.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.245 and 260

Hist: Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18

436-015-0037 MCO-Insurer Contracts

(1) An MCO must provide comprehensive medical services to all enrolled workers covered by the MCO-insurer contract according to the MCO's certification.

(2) An MCO may not contract exclusively with a single insurer. However, an MCO has up to one year from the effective date of its first contract to obtain contracts with more than one insurer. If the MCO has not obtained additional contracts within this time period, the MCO must provide the director with a report documenting the MCO's efforts to obtain additional contracts.

(3) An MCO may contract only with insurers. The contract must include the following terms and conditions:

(a) Who is governed by the contract;

(b) The covered place of employment must be within the authorized geographic service area;

(c) Insurers may contract with multiple MCOs to provide coverage for employers. All workers at any specific employer's location must be governed by the same MCO(s). When insurers contract with multiple MCOs each worker must have initial choice at the time of injury to select which MCO will manage their care except when the employer provides a coordinated health care program;

(d) Workers enrolled in an MCO must receive medical services as prescribed by the terms and conditions of the contract; and

(e) A continuity of care provision specifying how workers will receive medical services on open claims, including the following:

(A) Upon enrollment, allowing workers to continue to treat with the current medical service providers for at least 14 days after the mailing date of the notice of enrollment; and

(B) Upon termination or expiration of the MCO-insurer contract, allowing workers to continue treatment under ORS 656.245(4)(a).

(4) Notwithstanding the requirements of this rule, failure of the MCO to provide medical services does not relieve the insurers of their responsibility to ensure benefits are provided to workers under ORS chapter 656.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.245 and 260

Hist: Amended 3/11/19 as Admin. Order 19-053, eff. 4/1/19

436-015-0040 Reporting Requirements for an MCO

(1) In order to ensure the MCO complies with the requirements of these rules, each MCO must provide the director with a copy of the entire text of any MCO-insurer contract, signed by the insurer and the MCO, within 30 days of execution of such contracts. The MCO must submit any

amendments, addenda, or cancellations to the director within 30 days of execution.

(2) When an MCO-insurer contract contains a specific expiration or termination date, the MCO must provide the director with a copy of a contract extension, signed by the insurer and MCO, no later than the contract's date of expiration or termination. If the MCO does not provide the director with a copy of the signed contract extension, workers will no longer be subject to the contract after it expires or terminates.

(3) The MCO must submit any amendments to the certified plan to the director for approval. The MCO must not take any action based on a proposed amendment until the director approves the amendment.

(4) Within 45 days of the end of each calendar quarter, each MCO must provide the following information to the director, current on the last day of the quarter, as described in [Bulletin 247](#):

- (a) The quarter being reported;
- (b) MCO certification number; and
- (c) Membership listings by category of medical service provider (in coded form), including:
 - (A) Provider names;
 - (B) Specialty (in coded form);
 - (C) Tax ID number;
 - (D) National Provider Identifier (NPI) number; and
 - (E) Business address and phone number. When a medical service provider has multiple offices, only one office location in each geographic service area needs to be reported.

(5) By April 30 of each year, each MCO must provide the director with the following information for the previous calendar year:

- (a) A summary of any sanctions or punitive actions taken by the MCO against its members; and
- (b) A summary of actions taken by the MCO's peer review committee.

(6) By April 30 of each year, each MCO must report to the director denials and terminations of the authorization of come-along providers. The MCO's report must include the following:

- (a) Provider type (primary care physician, chiropractic physician, physician associate, or authorized nurse practitioner) reported by geographic service area (GSA).
- (b) The number of workers affected, reported by provider type.
- (c) Date of denial or termination.
- (d) One or more of the following reasons for each denial or termination:
 - (A) Provider failed to meet the MCO's credentialing standards within the last two years;
 - (B) Provider has been previously terminated from serving as an attending physician within the last two years;
 - (C) Treatment is not according to the MCO's service utilization process;

(D) Provider failed to comply with the MCO's terms and conditions after being granted come-along privileges; or

(E) Other reasons authorized by statute or rule.

(7) An MCO must report any new board members or shareholders to the director within 14 days of such changes. These parties must submit affidavits certifying they have no interest in an insurer or other non-qualifying employer as described under OAR 436-015-0009.

(8) Nothing in this rule limits the director's ability to require information from the MCO as necessary to monitor the MCO's compliance with the requirements of these rules.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.260

Hist: Amended 3/9/23, as Admin. Order 23-052, eff. 4/1/23

Amended 11/22/23 as Admin. Order 23-056, eff. 1/1/2024

SMC (physician assistant name change) ORS 183.335(7), (WCD 12-2024) eff. 6/6/24

436-015-0050 Record Keeping and Place of Business

(1) Every MCO must give the director notice of one Oregon location and mailing address where the MCO keeps records of the following:

- (a) Up-to-date membership listings of all MCO members;
- (b) Sanctions or punitive actions taken by the MCO against its members;
- (c) Actions taken by the MCO's peer review committee;
- (d) Utilization reviews performed identifying cases reviewed, issues involved, and action taken;
- (e) A profile analysis of each provider in the MCO;
- (f) Enrolled workers receiving treatment by come-along providers; and
- (g) All other records as necessary to ensure compliance with the certification requirements under OAR 436-015-0030.

(2) Records required by section (1) of this rule must be retained at the authorized Oregon location for three full calendar years.

(3) Each MCO provider must maintain medical records as provided by OAR 436-010-0240.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.260

Hist: Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18

436-015-0060 Commencement and Termination of Panel Providers

(1) Prospective new panel providers of an MCO must submit an application to the MCO. The directors, executive director, or administrator may approve the application for membership according to the membership requirements of the MCO. The MCO must verify that each new member meets all licensing, registration, and certification requirements necessary to practice in Oregon. If the MCO requires a membership fee, the fee must be the same for every category of medical service provider. An MCO may not require membership fees or other MCO administrative fees to be paid by come-along providers.

(2) Individual panel providers may elect to terminate their participation in the MCO or be subject to cancellation by the MCO according to the membership requirements of the MCO plan. Upon termination of a panel provider, the MCO must:

(a) Make alternate arrangements to provide continuing medical services for any affected workers under the plan; and

(b) Replace any terminated panel provider when necessary to maintain an adequate number of each category of medical service provider.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.260

Hist: Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18

436-015-0065 Monitoring and Auditing

(1) The director will monitor and conduct periodic audits of an MCO as necessary to ensure compliance with the MCO certification and performance requirements.

(2) All records of an MCO and its individual panel providers must be disclosed upon the director's request. These records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided for the codes.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.260

Hist: Includes content from 436-015-0100, repealed effective 4/1/18

Adopted 3/13/18, as Admin. Order 18-055, eff. 4/1/18

436-015-0070 Come-along Providers

(1) The MCO must authorize a physician, physician associate, or nurse practitioner who is not an MCO panel provider to provide medical services to an enrolled worker if:

(a) The nurse practitioner is an authorized nurse practitioner under ORS 656.245, the chiropractic physician or physician associate has certified to the director that the chiropractic physician or physician associate has reviewed required materials under ORS 656.799, or the physician is a primary care physician under ORS 656.260(4)(g);

(b) The physician, physician associate, or authorized nurse practitioner agrees to comply with MCO treatment standards, protocols, utilization review, peer review, dispute resolution, billing and reporting procedures, and fees for services under OAR 436-015-0090; and

(c) The physician, physician associate, or authorized nurse practitioner agrees to refer the worker to the MCO for specialized care that the worker may require, including physical therapy.

(2) The physician, physician associate, or authorized nurse practitioner who is not an MCO panel provider will be deemed to have maintained the worker's medical records and established a documented history of treatment, if the physician's, physician associate's, or nurse practitioner's medical records show treatment has been provided to the worker prior to the date of injury. Additionally, if a worker has selected a physician, physician associate, or authorized nurse practitioner through a private health plan, prior to the date of injury, that selected provider will be deemed to have maintained the worker's medical records and established a documented history of treatment prior to the date of injury.

(3) The MCO may not limit the length of treatment authority of a come-along provider unless such limits are stated in ORS chapter 656.

(4) Notwithstanding section (1), for those workers receiving their medical services from a facility that maintains a single medical record on the worker, but provides treatment by multiple primary care or chiropractic physicians, physician associates, or authorized nurse practitioners who are not MCO panel providers, the requirements of sections (1) and (2) will be deemed to be met. In this situation, the worker must select one primary care or chiropractic physician, physician associate, or authorized nurse practitioner to treat the compensable injury.

(5) Any questions or disputes relating to the worker's selection of a physician, physician associate, or authorized nurse practitioner who is not an MCO panel provider must be resolved under OAR 436-015-0110.

(6) Any disputes relating to a come-along provider's or other non-MCO provider's compliance with MCO standards and protocols must be resolved under OAR 436-015-0110.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.260

Hist: Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18

Amended 6/13/22 as Admin. Order 22-055, eff. 7/1/22

Amended 11/22/23 as Admin. Order 23-056, eff. 1/1/2024

SMC (physician assistant name change) ORS 183.335(7), (WCD 13-2024) eff. 6/6/24

436-015-0075 Worker Exams

When the MCO schedules a worker exam that includes a psychological evaluation, the appointment letter must:

(1) Inform the worker that a psychological evaluation is part of the exam; and

(2) State the reason for the psychological exam.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.260

Hist: Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18

436-015-0080 Suspension; Revocation

(1) Under ORS 656.260, the director may suspend or revoke an MCO's certification if:

(a) The director finds a serious danger to the public health or safety;

(b) The MCO is not providing services according to the terms of the certified MCO plan;

(c) There is a change in legal entity of the MCO that does not conform to the requirements of these rules;

(d) The MCO fails to comply with ORS chapter 656, OAR 436-009, 436-010, 436-015, or orders of the director;

(e) The MCO or any of its members commits any violation for which a civil penalty could be assessed under ORS 656.254 or 656.745;

(f) Any false or misleading information is submitted by the MCO or any member of the organization;

(g) The MCO continues to use the services of a health care practitioner whose license has been suspended or revoked by the licensing board; or

(h) The director determines that the MCO was or is formed, owned, or operated by a non-qualifying employer.

(2) The director will provide the MCO written notice of intent to suspend the MCO's certification.

(a) The notice will:

(A) Describe generally the acts of the MCO and the circumstances that would be grounds for suspension; and

(B) Advise the MCO of its right to a show cause hearing and the date, time, and place of the hearing.

(b) The director will serve the notice upon the MCO's designated in-state communication liaison and to the registered agent or other officer of the corporation upon whom legal process may be served at least 30 days before the scheduled date of the hearing.

(3) The show cause hearing on the suspension must be conducted as provided in OAR 436-015-0008(6).

(4) An order of suspension will suspend the MCO's authority to enter into new contracts with insurers for a specified period of time up to a maximum of one year. During the suspension, the MCO may continue to provide services under the contracts in effect at the time of the suspension.

(a) The director may set aside the suspension before the end of the suspension period if the director is satisfied of the MCO's current compliance, ability, and commitment to comply with ORS chapter 656, OAR 436-009, 436-010, 436-015, orders of the director, and the certified MCO plan.

(b) Before the end of the suspension period the director will determine if the MCO is in compliance with ORS chapter 656, OAR 436-009, 436-010, 436-015, orders of the director, and the certified MCO plan. If the MCO is in compliance the suspension will terminate on its designated date. If the MCO is not in compliance the suspension may be extended beyond one year without further hearing, or revocation proceedings may be initiated.

(5) The process for revocation of the certification of an MCO is as follows:

(a) The director will provide the MCO with notice of an order of revocation which:

(A) Describes generally the acts of the MCO and the circumstances that are grounds for revocation; and

(B) Advises the MCO that the revocation will become effective within 10 days after service of such notice upon the MCO, unless within 10 days the MCO corrects the grounds for the revocation to the satisfaction of the director or the MCO files an appeal as provided in OAR 436-015-0008(7).

(b) The director will serve the order upon the MCO's designated in-state communication liaison and to the registered agent or other officer of the corporation upon whom legal process may be served.

(c) A show cause hearing on the revocation will be conducted as provided in OAR 436-015-0008(6).

(d) If the director affirms the revocation, the revocation is effective 10 days after service of the order upon the MCO unless the MCO appeals the order.

(6) After revocation of an MCO's authority to provide services under these rules has been in effect for three years or longer, the MCO may petition the director to restore its authority by making application as provided in these rules.

(7) Notwithstanding section (5) of this rule, in any case where the director finds a serious danger to the public health or safety and sets forth specific reasons for such findings, the director may immediately revoke the certification of an MCO without providing the MCO a show cause hearing. Such order will be final, unless the MCO requests a hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order revoking the MCO certification. OAR 436-015-0008(6) outlines the process for review.

(8) Insurer contractual obligations to allow an MCO to provide medical services for workers are null and void upon revocation of the MCO certification by the director.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.260

Hist: Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18

Minor correction under ORS 183.335(7) (WCD 18-2020), filed and eff. 11/30/20

436-015-0090 Charges and Fees

(1) Billings for medical services under an MCO must be submitted in the form and format as prescribed in OAR 436-009. The payment of medical services may be less than, but must not exceed, the maximum amounts allowed under OAR 436-009.

(2) Notwithstanding section (1) of this rule, fees paid for medical services provided by come-along providers must not be less than fees paid to MCO panel providers for similar medical services.

(3) Payments to medical providers who are not under contract with the MCO are not subject to an MCO discount.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.245 and 260

Hist: Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18

436-015-0110 Dispute Resolution

(1) Disputes which arise between any party and an MCO must first be processed through the dispute resolution process of the MCO.

(2) The MCO must promptly provide a written summary of the MCO's dispute resolution process to anyone who requests it, or to any party or their representative disputing any action of the MCO or affected by a dispute. The written summary must include at least the following:

(a) The title, address, and telephone number of the contact person at the MCO who is responsible for the dispute resolution process;

(b) The types of issues the MCO will consider in its dispute resolution process;

(c) A description of the procedures and time frames for submission, processing, and decision at each level of the dispute resolution process including the right of an aggrieved party to request administrative review by the director if the party disagrees with the final decision of the MCO; and

(d) A statement that absent a showing of good cause, failure to timely appeal to the MCO shall preclude appeal to the director.

(3) The MCO must notify the worker and the worker's attorney when the MCO:

(a) Receives any complaint or dispute under this rule; or

**OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
MANAGED CARE ORGANIZATIONS**

**Administrative
Order No.
25-052**

(b) Issues any decision under this rule.

(4) Whenever an MCO denies a service, or a party otherwise disputes a decision of the MCO, the MCO must send written notice of its decision to all parties that can appeal the decision. If the MCO provides a dispute resolution process for the issue, the notice must include the following in bold text and formatted as follows:

Notice to the worker and all other parties:

If you want to appeal this decision, you must:

- Notify us in writing within 30 days of the mailing date of this notice**
- Send your written request for review to:**

{MCO name}

{MCO address}

If you have questions, contact {MCO contact person and phone number}.

If you do not notify us in writing within 30 days, you will lose all rights to appeal the decision, unless you show good cause. If you appeal within the 30-day timeframe, we will review the disputed decision and notify you of our final decision within 60 days of your request. After that, if you still disagree with our decision, you may appeal to the Department of Consumer and Business Services (DCBS) for further review. If you do not seek dispute resolution through us, you will lose your right to appeal to DCBS.

(5) If an MCO receives a complaint or dispute that is not included in the MCO dispute resolution process, the MCO must, within seven days from the date of receiving the complaint, notify the parties in writing of their right to request review by the director under OAR 436-015-0008. The notice must include the following in bold text and formatted as follows:

Notice to the worker and all other parties:

{MCO name} does not have a process to review the type of issue you have raised. To pursue this issue you must request administrative review by the Department of Consumer and Business Services (DCBS) within 60 days of the mailing date of this notice.

If you do not notify DCBS in writing within 60 days, you will lose all rights to appeal the decision.

Send your written request for review to:

DCBS Workers' Compensation Division

Medical Resolution Team

350 Winter Street NE

PO Box 14480

Salem OR 97309-0405

For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.

(6) The time frame for resolution of the dispute by the MCO may not exceed 60 days from the date the MCO receives the dispute to the date it issues its final decision. After the MCO resolves a dispute under ORS 656.260(15), the MCO must notify all parties to the dispute in writing with an explanation of the reasons for the decision. If the worker's attorney has notified the insurer in writing of representation, the MCO must also send a copy of the explanation of the reasons for the decision to the attorney. This notice must inform the parties of the next step in the process, including the right of an aggrieved party to request administrative review by the director under OAR 436-015-0008. The notice must include the following in bold text and be formatted as follows:

Notice to the worker and all other parties:

If you want to appeal this decision, you must do so within 60 days from the mailing date of this notice.

If you do not notify the Department of Consumer and Business Services (DCBS) in writing within 60 days, you will lose all rights to appeal the decision.

Send your written request for review to:

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Salem OR 97309-0405

For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.

(7) If the MCO fails to issue a decision within 60 days, the MCO's initial decision is automatically deemed affirmed. The parties may immediately proceed as though the MCO had issued an order affirming the MCO decision. The MCO must notify the parties of the next step in the process, including the right of an aggrieved party to request administrative review by the director under OAR 436-015-0008 including the appeal rights provided in (6) of this rule.

(8) The director may assist in resolution of a dispute before the MCO. The director may issue an order to further the dispute resolution process. Any of the parties also may request in

writing that the director assist in resolution if the dispute cannot be resolved by the MCO.

Stat. Auth.: ORS 656.260, 656.726(4)

Stats. Implemented: ORS 656.260

Hist: Amended 3/5/24 as Admin. Order 24-052, eff. 4/1/24

Amended 3/11/25 as Admin. Order 24-051, eff. 4/1/25

436-015-0120 Sanctions and Civil Penalties

(1) Complaints pertaining to violations of these rules must be sent to the director.

(2) The director may investigate an alleged rule violation. The investigation may include, but is not limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the complaint, or consultation with an appropriate panel of the medical provider's peers, chosen in the manner provided in OAR 436-010-0330.

(3) If the director finds any violation of OAR 436-015, or if the MCO fails to meet any of the requirements of the certified plan, the director may impose one or more of the following sanctions against an MCO:

(a) Reprimand by the director;

(b) Civil penalty as provided under ORS 656.745(2). In determining the amount of penalty to be assessed, the director will consider:

(A) The degree of harm inflicted on the worker, insurer, or medical provider;

(B) Previous violations; and

(C) Evidence of willful violation; or

(c) Suspension or revocation of the MCO's certification under OAR 436-015-0080.

(4) If the director determines that an insurer has entered into a contract with an MCO that violates OAR 436-015 or the MCO's certified plan, the insurer will be subject to civil penalties as provided in ORS 656.745.

(5) If an insurer or someone who is not a certified MCO acting on the insurer's behalf engages in managed care activities prohibited under these rules, the director may impose a sanction or civil penalty.

Stat. Auth.: ORS 656.260, 656.726(4) | Stats. Implemented: ORS 656.260 and 656.745

Hist: Amended 12/17/19 as Admin. Order 19-062, eff. 1/1/20

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**Administrative
Order No.
22-068**

**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 030
CLAIM CLOSURE AND RECONSIDERATION**

Effective Jan. 1, 2024

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436-030-0003 Purpose, Applicability, Forms, and Bulletins

(1) Purpose. The purpose of the rules in OAR 436-030 is to provide standards, conditions, procedures, and reporting requirements for:

- (a) Requests for closure by the worker;
- (b) Claim closure under ORS 656.268(1);
- (c) Determining medically stationary status;
- (d) Determining temporary disability benefits;
- (e) Awards of permanent partial disability;

- (f) Determining permanent total disability awards;
- (g) Review for reduction of permanent total disability awards;
- (h) Review of prior permanent partial disability awards; and
- (i) Reconsideration of notices of closure.

(2) Applicability of rules.

(a) Except as provided in subsections (c) and (d) of this section, the rules in OAR 436-030 apply to all accepted claims for workers' compensation benefits and all claims closed on or after the effective date of these rules.

(b) All orders the division issues to carry out the statute and the rules in OAR 436-030 are considered orders of the director.

(c) For claims in which the worker became medically stationary before July 2, 1990, OAR 436-030-0020, 436-030-0030, and 436-030-0050 as adopted by WCD Administrative Order 13-1987, effective January 1, 1988, will apply.

(d) OAR 436-030-0055(3)(b), (3)(d), and (4)(a) apply to all claims with dates of injury on or after January 1, 2002.

(e) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(3) Availability of forms and bulletins. The forms and bulletins referenced in these rules are available on the division's website at <https://wcd.oregon.gov/forms/Pages/forms.aspx> and <https://wcd.oregon.gov/forms/Pages/bulletins.aspx>.

Statutory authority: ORS 656.268, 656.726

Statutes implemented: ORS 656.005, 656.206, 656.210, 656.212, 656.214, 656.262, 656.268, 656.273, 656.278, 656.325, 656.726

Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

Statutory minor correction (rule reference in 2(a))— ORS 183.335(7), filed and effective 6/17/24

436-030-0005 Definitions

Unless a term is defined in these rules or the context otherwise requires, the definitions of ORS chapter 656 are incorporated by reference and made part of these rules.

(1) "Authorized nurse practitioner" means a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010.

(2) "Board" means the Workers' Compensation Board and includes its Hearings Division.

(3) "Day" means calendar day unless otherwise specified (e.g., "working day").

(4) "Direct medical sequela" means a condition that is clearly established medically and originates or stems from an accepted condition.

(5) "Director" means the director of the Department of Consumer and Business Services, or the director's designee.

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

(7) "Instant fatality" means a compensable claim for death benefits when the worker dies within 24 hours of the injury.

(8) "Insurer" means the State Accident Insurance Fund; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon, a self-insured employer, or a self-insured employer group.

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(9) **"Irreversible findings"** has the same meaning as described in OAR 436-035-0005(7).

(10) **"Mailed" or "mailing date,"** for the purposes of determining timeliness under these rules, means the date a document is postmarked. Requests submitted by fax will be considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date received by the division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

(11) **"Notice of Closure"** means a notice to the worker, estate, or beneficiary issued by the insurer to:

- (a) Close an accepted disabling claim, including fatal claims;
- (b) Correct, rescind, or rescind and reissue a Notice of Closure previously issued; or
- (c) Reduce permanent total disability to permanent partial disability.

(12) **"Reconsideration"** means review by the director of an insurer's Notice of Closure.

(13) **"Statutory closure date"** means the date the claim satisfies the criteria for closure under ORS 656.268(1)(b) and (c).

(14) **"Statutory appeal period"** means the time frame for appealing a Notice of Closure or Order on Reconsideration.

(15) **"Work disability,"** for purposes of determining permanent disability, means the separate factoring of impairment as modified by age, education, and adaptability to perform the job at which the worker was injured.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.005, 656.268, and 656.726
Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

436-030-0007 Administrative Review

(1) Notices of Closure issued by insurers are appealed to the director and processed in accordance with the reconsideration procedures described in OAR 436-030-0115 through OAR 436-030-0185, except Notices of Closure under (3)(b) of this rule, when:

- (a) The worker was determined medically stationary after July 1, 1990; or
- (b) The claim qualifies for closure under ORS 656.268(1)(b) or (c).

(2) The director may abate, withdraw, or amend the Order on Reconsideration during the 30-day appeal period for the Order on Reconsideration.

(3) The following matters are brought before the board:

- (a) Orders on Reconsideration issued under these rules.
- (b) Notices of Closure that rescind permanent total disability under ORS 656.206.

(c) Any other action taken under these rules where a worker's right to compensation or the amount thereof is directly an issue under ORS chapter 656.

(4) Contested Case Hearings of Sanctions and Civil Penalties: Under ORS 656.740, any party aggrieved by a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254, 656.735, or 656.745 may request a hearing by the board as follows:

(a) The party must send the request for hearing in writing to the director within 60 days after the mailing date of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The division will forward the request and other pertinent information to the board.

(c) An Administrative Law Judge from the board, acting on behalf of the director, will conduct the hearing in accordance with ORS 656.740 and ORS Chapter 183.

(5) Director's Administrative Review of other actions: Except as covered under sections (1) through (4) of this rule, any party seeking an action or decision by the director or aggrieved by an action taken by any other party under these rules, may request administrative review by the director subject to the following:

(a) The party must send the request in writing to the director within 90 days of the disputed action and must specify the grounds upon which the action is disputed; and

(b) The director may require and allow such evidence as is deemed appropriate to complete the review.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.268, 656.726, 656.740
Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
SMC (repeal of ORS 656.750)— ORS 183.335(7), filed and effective 6/18/24

436-030-0015 Insurer Responsibility

(1) When an insurer issues a Notice of Closure ([Form 1644](#)), the insurer is responsible for:

(a) Providing the director, the parties, and the worker's attorney if the worker is represented, a copy of the Notice of Closure, a copy of the Notice of Closure Worksheet ([Form 2807](#)) upon which the Notice is based, a completed Insurer Notice of Closure Summary ([Form 1503](#)), and an Updated Notice of Acceptance at Closure that specifies which conditions are compensable, as prescribed in OAR 436-030-0020;

(b) Maintaining a copy of the worksheet and records upon which the Notice of Closure is based in its claim file for audit purposes under OAR 436-050; and

(c) Issuing the Updated Notice of Acceptance at Closure on the same date as the Notice of Closure.

(A) The Updated Notice of Acceptance at Closure must contain the following title, information, and language:

(i) Title: "Updated Notice of Acceptance at Closure";

(ii) Information: A list of all compensable conditions, even if a condition was denied, ordered accepted by litigation, and is under appeal. Any conditions under appeal and those which were the basis for this claim opening must be specifically identified; and

(iii) Language, in bold print:

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"Notice to Worker: This notice restates and includes all prior acceptances. The conditions that were the basis of this claim opening were the only conditions considered at the time of claim closure. The insurer or self-insured employer is not required to pay any disability compensation for any condition specifically identified as under appeal, unless and until the condition is found to be compensable after all litigation is complete. Appeal of any denied conditions or objections to this notice will not delay claim closure. Any condition found compensable after the Notice of Closure is issued will require the insurer to reopen the claim for processing of that condition. If you believe a condition has been incorrectly omitted from this notice, or this notice is otherwise deficient, you must communicate the specific objection to the insurer in writing.";

(B) In the case of an instant fatality, the Updated Notice of Acceptance may be combined with the Notice of Closure if the following is included:

- (i)** Title: "Updated Notice of Acceptance and Closure";
- (ii)** Information: A statement that beneficiaries may be entitled to death benefits under ORS 656.204 and 656.208, and the medically stationary date; and
- (iii)** Language, in bold print:

"Notice to Worker's Beneficiary or Estate: This notice restates any prior acceptances. The insurer is required to determine the appropriate benefits to be paid to any beneficiaries and begin those payments within 30 days of the mailing date of this notice.

If you disagree with the notice of acceptance, you may appeal the decision to the Workers' Compensation Board, 2601 25th Street SE, Suite 150, Salem, OR 97302-1280 within 30 days of the mailing date.

A beneficiary who was mailed this notice may request reconsideration of the notice by the Workers' Compensation Division, Appellate Review Unit, 350 Winter Street NE, PO Box 14480 Salem, OR 97309-0405 within 60 days of the mailing date of this notice.

Beneficiaries who were not mailed a copy of this notice may request reconsideration of this notice within one year of the date this notice was mailed to the estate of the worker.

If you have questions about this notice, you may contact the Ombuds Office for Oregon Workers, the Workers' Compensation Division, or consult with an attorney."

(C) If the "Initial Notice of Acceptance" is issued at the same time as the "Updated Notice of Acceptance at Closure," both titles must appear near the top of the document.

(D) When an omission or error requires correcting an Updated Notice of Acceptance at Closure, the document must be clearly titled "Corrected Updated Notice of Acceptance at Closure."

(2) The insurer or self-insured employer is not required to pay any disability compensation for any condition under appeal and

specifically identified as such, unless and until the condition is found to be compensable after all litigation is complete.

(3) Copies of Notices of Refusal to Close must be mailed to the director and the parties, and to the worker's attorney, if the worker is represented.

(4) In claims with a date of injury on or after January 1, 2005, where the worker has not returned to regular work and ORS 656.726(4)(f) does not apply, or in claims with a date of injury on or after January 1, 2006, when the worker has not been released to regular work and ORS 656.726(4)(f) does not apply, the insurer must consider:

- (a)** The worker's age at the time the notice is issued;
- (b)** Adaptability to return to employment;
- (c)** The worker's level of education; and
- (d)** The worker's work history, including an accurate

description of the physical requirements of the worker's job held at the time of injury, for the period from five years before the date of injury to the mailing date of the Notice of Closure with dates or period of time spent at each position, tasks performed or level of specific vocational preparation (SVP), and physical requirements. If the insurer cannot obtain five years of work history despite all reasonable efforts, the insurer must document its efforts and provide as much work history as it can obtain.

(5) In claims where the date of injury is before January 1, 2005, the worker has not returned or been released to regular work, ORS 656.726(4)(f) does not apply, and the claim involves injury to, or disease of, unscheduled body parts, areas, or systems, the insurer must consider:

- (a)** The worker's age at time the notice is issued;
- (b)** Adaptability to return to employment;
- (c)** The worker's level of education; and
- (d)** The worker's work history, including an accurate

description of the physical requirements of the worker's job held at the time of injury, for the period from five years before the date of injury to the mailing date of the Notice of Closure with dates or period of time spent at each position, tasks performed or level of specific vocational preparation (SVP), and physical requirements.

(6) The insurer must consider any other records or information pertinent to claim determination prior to issuing a Notice of Closure.

(7) The insurer must notify the worker and the worker's attorney, if the worker is represented, in writing, when the insurer receives information that the worker's claim qualifies for closure under these rules.

(a) The insurer must send the written notice within three working days from the date the insurer receives the information, unless the claim has already been closed.

(b) The notice must advise the worker of impending claim closure and that any temporary disability benefits currently being paid will end soon.

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(8) The insurer must, within 14 days of closing the claim, provide the worker's attorney the same documents relied upon for claim closure.

(9) The insurer may not issue a Notice of Closure on an accepted nondisabling claim. Notices of Closure issued by the insurer in violation of this rule are void and without legal effect. Medically stationary status in nondisabling claims may be documented by the attending physician's statement of medically stationary status.

(10) When a condition is accepted after a closure and the claim has been reopened under ORS 656.262, the insurer must issue a Notice of Closure, considering only the newly accepted condition.

(11) Denials issued under ORS 656.262(7)(b), must clearly identify the phrase "major contributing cause" in the text of the denial.

(12) When a claim is closed where a designation of paying agent order (ORS 656.307) has been issued and the responsibility issue is not final by operation of law, the insurer processing the claim at the time of closure must send copies of the closure notice to the worker, the worker's attorney if the worker is represented, the director, and all parties involved in the responsibility issue.

(13) Forms [1503](#), [1644](#), and [2807](#) are published with [Bulletin 139](#).

(14) The insurer must mail or deliver the notice required under OAR 436-060-0015(8).

Statutory authority: ORS 656.268 (OL2022, ch. 73, sections 4 & 5), 656.726
Statutes implemented: ORS 656.262, 656.26 (OL2022, ch. 73, sections 4 & 5)8, 656.331, 656.726
Hist: Amended 12/19/22 as Admin. Order 22-068, eff. 1/1/24

436-030-0017 Requests for Claim Closure by the Worker

(1) A worker may request claim closure from the insurer. The insurer must issue a Notice of Closure or Notice of Refusal to Close within 10 days of receipt of a written request for claim closure from the worker or the worker's attorney.

(2) If an insurer issues a Notice of Refusal to Close, the notice must be clearly titled "Notice of Refusal to Close" and it must include:

- (a) Name of the worker;
- (b) Date of injury;
- (c) Insurer's claim number;
- (d) Mailing date of the notice;
- (e) The accepted and denied conditions;
- (f) Rationale for the insurer's decision; and
- (g) The following language, in bold print:

"If you disagree with this Notice of Refusal to Close your claim, you must file a letter of disagreement with the Workers' Compensation Board within sixty (60) days from the date of this notice. Your letter must state that you want a hearing, note your address, and include the date of your accident if known. You must mail your letter of disagreement to the Workers' Compensation Board, 2601 25th Street SE, Suite 150, Salem, OR 97302-1280. If your

claim qualifies and you request it, you may receive an expedited hearing (within 30 days). Your request cannot, by law, affect your employment. If you do not file your letter of disagreement within sixty (60) days from the date of this notice, your hearing will be denied as the appeal time has passed. You may be represented by an attorney if you choose."

(3) If the worker disagrees with the Notice of Refusal to Close, the worker may request a hearing from the board.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.268, 656.319, 656.726, 656.745,
Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

436-030-0020 Requirements for Claim Closure

(1) **Issuance of a Notice of Closure.** Unless the worker is enrolled and actively engaged in an authorized training plan under OAR 436-120, the insurer must issue a Notice of Closure on an accepted disabling claim within 14 days when:

(a) Medical information establishes that there is sufficient information to determine the extent of permanent disability and indicates that the worker is medically stationary;

(b) The compensable injury is no longer the major contributing cause of the worker's combined or consequential condition(s), a major contributing cause denial has been issued, and there is sufficient information to determine the extent of permanent disability;

(c) The worker fails to seek medical treatment for 30 days for reasons within the worker's control and the requirements for claim closure under OAR 436-030-0034 have been met;

(d) The worker fails to attend a mandatory closing examination for reasons within the worker's control and the requirements for claim closure under OAR 436-030-0034 have been met; or

(e) A worker receiving permanent total disability benefits has materially improved and is capable of regularly performing work at a gainful and suitable occupation.

(2) **Sufficient Information.** For purposes of determining the extent of permanent disability, except as provided in section (14) of this rule for closure after training, "sufficient information" requires: a qualifying statement of no permanent disability under subsection (a) of this section or a qualifying closing report under subsection (b) of this section. Additional documentation is required under subsection (c) of this section unless there is clear and convincing evidence that an attending physician or authorized nurse practitioner has released the worker to the job held at the time of injury or that the worker has returned to the job held at the time of injury.

(a) **Qualifying statements of no permanent disability.** A statement indicating that there is no permanent disability is sufficient if it meets all of the following requirements:

(A) **Qualified providers.** An authorized nurse practitioner or attending physician must provide or concur with the statement.

(B) **Support by the medical record.** The statement must be supported by the medical record. If the medical record reveals

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otherwise, a closing examination and report specified under subsection (b) of this section are required.

(C) In initial injury claims. In an initial injury claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment due to an accepted condition or a direct medical sequela of an accepted condition; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted condition or a direct medical sequela of an accepted condition.

(D) In new or omitted condition claims. In a new or omitted condition claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(E) In aggravation claims. In an aggravation claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(F) In occupational disease claims. In an occupational disease claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(b) Qualifying closing reports. A closing medical examination and report are required if there is a reasonable expectation of permanent disability. A closing report is sufficient if it meets all of the following requirements:

(A) Qualified providers. A type A attending physician or a chiropractic physician serving as the attending physician must provide or concur with the closing report.

(B) Release to regular work. If the worker has no permanent work restriction and the provider identified in paragraph (A) of this rule has not already clearly established the following information, the closing report must include a statement indicating that:

(i) The worker has no permanent work restriction; or

(ii) The worker is released, without restriction, to the job held at the time of injury.

(C) In initial injury claims. In an initial injury claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment due to an accepted condition or a direct medical sequela of an accepted condition; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted condition or a direct medical sequela of an accepted condition.

(D) In new or omitted condition claims. In a new or omitted condition claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(E) In aggravation claims. In an aggravation claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(F) In occupational disease claims. In an occupational disease claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease; and

(ii) Any permanent work restriction that:

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(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(c) Additional documentation. Unless there is clear and convincing evidence that an attending physician or authorized nurse practitioner has released the worker to the job held at the time of injury (for dates of injury on or after January 1, 2006) or that the worker has returned to the job held at the time of injury, all of the following is required:

(A) An accurate description of the physical requirements of the worker's job held at the time of injury, which has been provided by certified mail to the worker and the worker's attorney, if any, either before closing the claim or at the time the claim is closed, unless the record clearly establishes the physical requirements of the worker's job held at the time of injury;

(B) The worker's wage established consistent with OAR 436-060;

(C) The worker's date of birth;

(D) Except as provided in OAR 436-030-0015(4)(d), the worker's work history for the period beginning five years before the date of injury to the mailing date of the Notice of Closure, including tasks performed or level of SVP, and physical demands; and

(E) The worker's level of formal education.

(3) When determining disability and issuing the Notice of Closure, the insurer must apply all statutes and rules consistent with their provisions, particularly as they relate to major contributing cause denials, worker's failure to seek treatment, worker's failure to attend a mandatory examination, medically stationary status, temporary disability, permanent partial and total disability, and review of permanent partial and total disability.

(4) When issuing a Notice of Closure ([Form 1644](#)), the insurer must prepare and attach a Notice of Closure Worksheet ([Form 2807](#)), as described by bulletin of the director, and an Insurer Notice of Closure Summary ([Form 1503](#)).

(5) The Notice of Closure (Form 1644) is effective the date it is mailed to the worker and to the worker's attorney if the worker is represented, or to the worker's estate if the worker is deceased, regardless of the date on the Notice itself.

(6) The Notice of Closure (Form 1644) must be in the form and format prescribed by the director in these rules and include only the following:

(a) The worker's name, address, and claim identification information;

(b) The appropriate dollar value of any individual scheduled or unscheduled permanent disability based on the value per degree for injuries occurring before January 1, 2005 or, for injuries occurring on or after January 1, 2005, the appropriate dollar value of any "whole person" permanent disability, including impairment and work disability as determined appropriate under OAR 436-035;

(c) The body part(s) awarded disability, coded to the table of body part codes as prescribed by the director;

(d) The percentage of loss of the specific body part(s), including either the number of degrees that loss represents as appropriate for injuries occurring before January 1, 2005, or the percentage of the whole person the worker's loss represents as appropriate for injuries occurring on or after January 1, 2005;

(e) If there is no permanent disability award for this Notice of Closure, a statement to that effect;

(f) The duration of temporary total and temporary partial disability compensation;

(g) The date the Notice of Closure was mailed;

(h) The medically stationary date or the date the claim statutorily qualifies for closure under OAR 436-030-0035 or 436-030-0034;

(i) The date the worker's aggravation rights end;

(j) The appeal rights of the worker and any beneficiaries;

(k) A statement that the worker has the right to consult with the Ombuds Office for Oregon Workers;

(l) For claims with dates of injury before January 1, 2005, the rate in dollars per degree at which permanent disability, if any, will be paid based on date of injury as identified in [Bulletin 111](#);

(m) For claims with dates of injury on or after January 1, 2005, the state's average weekly wage applicable to the worker's date of injury;

(n) The worker's return to work status;

(o) A general statement that the insurer has the authority to recover an overpayment;

(p) A statement that the worker has the right to be represented by an attorney; and

(q) A statement that the worker has the right to request a vocational eligibility evaluation under ORS 656.340.

(7) The Notice of Closure ([Form 1644](#)) must be accompanied by the following:

(a) The brochure "Understanding Claim Closure and Your Rights";

(b) A copy of summary worksheet [Form 2807](#) containing information and findings that result in the data appearing on the Notice of Closure;

(c) An accurate description of the physical requirements of the worker's job held at the time of injury unless it is not required under (2)(a) or (2)(c) of this rule or it was previously provided under (2)(c)(A) of this rule;

(d) The Updated Notice of Acceptance at Closure which clearly identifies all accepted conditions in the claim and specifies those which have been denied and are on appeal or which were the basis for this opening of the claim; and

(e) A cover letter that:

(A) Specifically explains why the claim has been closed (e.g., expiration of a period of suspension without the worker resolving the problems identified, an attending physician stating

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the worker is medically stationary, worker failure to treat without attending physician authorization or establishing good cause for not treating);

(B) Lists and describes enclosed documents; and

(C) Notifies the worker about the end of temporary disability benefits, if any, and the anticipated start of permanent disability benefits, if any.

(8) A copy of the Notice of Closure must be mailed to each of the following persons at the same time, with each copy clearly identifying the intended recipient:

(a) The worker;

(b) The employer;

(c) The director; and

(d) The worker's attorney, if the worker is represented.

(9) If the worker is deceased at the time the Notice of Closure is issued:

(a) The worker's copy of the notice must be addressed to the estate of the worker and mailed to the worker's last known address.

(b) Copies of the notice may be mailed to any known or potential beneficiaries to the worker's estate. If a copy of the notice is mailed to a beneficiary, it must be mailed by both regular mail and certified mail return receipt requested.

(10) The worker's copy of the Notice of Closure must be mailed by both regular mail and certified mail return receipt requested.

(11) An insurer may use electronically produced Notice of Closure forms if consistent with the form and format prescribed by the director.

(12) Insurers may allow adjustments of benefits awarded to the worker under the documentation requirements of OAR 436-060-0170 for the following purposes:

(a) To recover payments for permanent disability which were made prematurely;

(b) To recover overpayments for temporary disability; and

(c) To recover overpayments for other than temporary disability such as prepaid travel expenses where travel was not completed, prescription reimbursements, or other benefits payable under ORS 656.001 to 656.794.

(13) The insurer may allow overpayments made on a claim with the same insurer to be deducted from compensation to which the worker is entitled but has not yet been paid.

(14) Under ORS 656.268(10), if, after claim closure, the worker becomes enrolled and actively engaged in an authorized training plan under OAR 436-120, the insurer must again close the claim consistent with the following:

(a) The claim must be closed when the worker ceases to be enrolled and actively engaged in the training and:

(A) The worker is medically stationary;

(B) The worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions; or

(C) The claim otherwise qualifies for closure under OAR 436-030-0034.

(b) If the worker is medically stationary, there must be a current (within 60 days before closure) determination of medically stationary status.

(c) For claims with dates of injury on or after January 1, 2005, permanent disability must be redetermined for work disability only. For claims with dates of injury before January 1, 2005, permanent disability must be redetermined for unscheduled disability only.

(d) Except for claims closed under ORS 656.268(1)(c), the insurer must have sufficient information to redetermine work disability or unscheduled disability. The requirements in section (2) of this rule regarding sufficient information apply only as necessary for the redetermination, as follows:

(A) For claims with dates of injury on or after January 1, 2005, the insurer must have sufficient information to determine work disability under OAR 436-035-0012. An evaluation of the adaptability factor of work disability under OAR 436-035-0012(7) through (13) must be based on a current (within 60 days before closure) medical determination of the worker's residual functional capacity.

(B) For claims with dates of injury before January 1, 2005, the insurer must have sufficient information to determine unscheduled disability under OAR 436-035-0008(2). An evaluation of unscheduled disability must be based on a current (within 60 days before closure) medical determination.

(15) When, after a claim is closed, the insurer changes or is ordered to change the worker's weekly wage upon which calculation of the work disability portion of a permanent disability award may be based, the insurer must notify the parties and the division of the change and the effect of the change on any permanent disability award. For purposes of this rule, the insurer must complete [Form 1502](#) consistent with the instructions of the director and distribute it within 14 days of the change.

Statutory authority: ORS 656.268 (OL2022, ch. 73, sections 4 & 5), 656.726

Statutes implemented: ORS 656.210, 656.212, 656.214, 656.268 (OL2022, ch. 73, sections 4 & 5), 656.726, 656.745

Hist: Amended 12/19/22 as Admin. Order 22-068, eff. 1/1/24

436-030-0023 Correcting and Rescinding Notices of Closure

(1) An insurer may rescind or correct its Notice of Closure prior to the expiration of the appeal period for that notice and prior to or on the same day that the director receives a request for reconsideration of the Notice of Closure.

(2) The form, format, and completion of the Correcting and Rescinding Notices of Closure are the same as those of the Notice of Closure except that, to correct a Notice of Closure, a [Form 1644c](#) must be used and, to rescind a Notice of Closure, a [Form 1644r](#) must be used. An insurer may rescind and reissue a Notice of Closure by using a Form 1644 when such actions can be accomplished at the same time, the claim remains closed, and other provisions of these rules are met.

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(3) The "Date of closure (mailing date)" on the Correcting or Rescinding Notice of Closure must be the date the correction or rescission is mailed. The mailing date of the Notice of Closure being rescinded or corrected must be identified within the body of the Correcting or Rescinding Notice of Closure.

(4) The worker's copy of the Correcting and Rescinding Notices of Closure must be mailed by both regular mail and certified mail return receipt requested, consistent with OAR 436-030-0020(8) and (10).

(5) Rescinding Notices of Closure, [Form 1644r](#), are used to rescind the Notice of Closure and return the claim to open status. Examples of appropriate uses of Rescinding Notices of Closure include, but are not limited to:

(a) The worker was not medically stationary at the time the Notice of Closure was issued; and

(b) The closure was otherwise premature.

(6) The Rescinding Notice of Closure must:

(a) Advise the worker that the claim remains open and no aggravation rights end date has been established, if it is rescinding the first closure of the claim;

(b) Initiate an appeal period as provided in OAR 436-030-0145(1) during which any request for reconsideration must be received by the director;

(c) Explain the reason for the action being taken; and

(d) Be distributed and mailed to the parties consistent with these rules.

(7) When a Notice of Closure granting only temporary disability has been issued, if the insurer determines the worker's medically stationary status is unchanged and the worker is entitled to an award of permanent disability, the insurer must use a Notice of Closure, Form 1644, to rescind and reissue the closure. In such cases, the Notice of Closure must:

(a) Contain all required information consistent with these rules;

(b) Bear the heading "Rescind and Reissue";

(c) Explain the reason the action is being taken;

(d) Identify the permanent disability award being granted consistent with OAR 436-030 and 436-035;

(e) Establish a new appeal period as provided in OAR 436-030-0145(1);

(f) Set a new aggravation rights end date if the Notice of Closure being rescinded is the first closure of the claim; and

(g) Be distributed and mailed to the parties consistent with these rules.

(8) Correcting Notices of Closure, [Form 1644c](#), are used to correct errors or omissions and do not change the closure status or the action taken by the Notice of Closure being corrected. Correcting Notices of Closure may not be used to grant permanent disability in claims where the Notice of Closure being corrected did not include an award of permanent disability. Examples of appropriate uses of Correcting Notices of Closure include, but are not limited to:

(a) Permanent disability award computation errors (dollars, degrees, percentages);

(b) An incorrect "mailing date";

(c) Return-to-work status errors or omissions; and

(d) Incorrect or incomplete statement of temporary disability.

(9) A Correcting Notice of Closure must:

(a) Be issued when the director has instructed the insurer to do so because the Notice of Closure did not contain the information required by OAR 436-030-0020(4);

(b) Not be used to add a new condition to the claim closure, rate a new condition not considered in the Notice of Closure being corrected, or rescind a Notice of Closure;

(c) State in the body of the correcting notice only the information being corrected on the Notice of Closure and the basis for the correction;

(d) Not change the appeal period for the Notice of Closure being corrected; and

(e) Initiate a new appeal period as provided in OAR 436-030-0145(1) during which any request for reconsideration must be received, but only for those items being corrected.

Statutory authority: ORS 656.268, ORS 656.726

Statutes implemented: ORS 656.210, 656.212, 656.214, 656.268, 656.270, 656.726, 656.745

Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

436-030-0034 Administrative Claim Closure

(1) The insurer must close a claim when the worker is not medically stationary and the worker fails to seek treatment for more than 30 days without the instruction or approval of the attending physician or authorized nurse practitioner and for reasons within the worker's control. In order to close a claim under this section, the insurer must:

(a) Wait for the 30-day lack of treatment period to expire or any additional time period recommended by the attending physician or authorized nurse practitioner before sending the worker written notification by certified and regular mail, with a copy sent to the worker's attorney if the worker is represented, informing the worker of the following:

(A) The worker's responsibility to seek medical treatment in a timely manner;

(B) The consequences for failing to seek treatment in a timely manner which include, but are not limited to, claim closure and possible loss or reduction of a disability award; and

(C) The claim will be closed unless the worker establishes within 14 days from the date the letter was sent certified mail that:

(i) Treatment has resumed by attending an existing appointment or scheduling a new appointment; or

(ii) The reasons for not treating were outside the worker's control.

(b) Wait the 14-day period given in the notification letter to allow the worker to provide evidence that the lack of treatment was either authorized by the attending physician or authorized nurse practitioner or beyond the worker's control.

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(c) Determine whether claim closure is appropriate based on the information received.

(d) Rate all permanent disability apparent in the record at the time of claim closure. This includes, but is not limited to, any irreversible findings.

(e) Use 30 days from the last treatment provided or any additional time period authorized by the attending physician or authorized nurse practitioner as the date the claim qualifies for closure on the Notice of Closure.

(2) Regardless of whether the worker is medically stationary, the insurer must close a claim when a worker has not sought treatment for more than 30 days with a health care provider authorized under ORS 656.005 and ORS 656.245 (e.g., a worker enrolled in a managed care organization (MCO) who treats with a physician outside the MCO is not treating with an authorized health care provider). To close a claim under this section, the insurer must follow the requirements in section (1) of this rule and inform the worker that the reason for the impending closure is because the worker failed to treat with an authorized health care provider.

(3) A claim must be closed, regardless of whether the worker is medically stationary, when the worker fails to attend a mandatory closing examination for reasons within the worker's control. To close a claim under this section, the insurer must:

(a) Inform the worker in writing sent by certified and regular mail, with a copy sent to the worker's attorney if the worker is represented, at least 10 days prior to the mandatory closing examination of:

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

(B) The worker's responsibility to attend the examination;

(C) The consequences for failing to attend, which include, but are not limited to, claim closure and the possible loss or reduction of a disability award; and

(D) The worker's responsibility to provide, within seven days from the date of the scheduled examination, information to the insurer regarding why the examination was not attended, if the reason was beyond the worker's control.

(b) Wait seven days from the date of the missed examination to allow the worker to demonstrate good cause for failing to attend before closing the claim.

(c) Rate all permanent disability apparent in the record at the time of claim closure. This includes, but is not limited, to any irreversible findings.

(d) Use the date of the failed mandatory closing examination as the date the claim qualifies for closure on the Notice of Closure.

(4) The insurer may close the claim under section (1) of this rule, regardless of whether the worker is medically stationary, when a closing examination has been scheduled between a worker and attending physician directly and the worker fails to attend the examination.

(5) A claim may be closed when the worker's otherwise compensable injury is not medically stationary and a major

contributing cause denial has been issued on an accepted combined condition.

(a) The major contributing cause denial must inform the worker that claim closure may result from the issuance of the denial and provide all other information required by these rules.

(b) When a major contributing cause denial has been issued following the acceptance of a combined condition, the date the claim qualifies for closure is the date the insurer receives sufficient information to determine the extent of any permanent disability under OAR 436-030-0020(2) or the date of the denial, whichever is later.

(6) When two or more of the above events occur concurrently, the earliest date the claim qualifies for closure is used to close the claim.

(7) The attending physician or authorized nurse practitioner, if the worker has one, must be copied on all notification and denial letters applicable to this rule.

(8) When the director has issued a suspension order under OAR 436-060-0095 or OAR 436-060-0105, the date the claim qualifies for closure is the date of the suspension order.

Statutory authority: ORS 656.262, 656.268, 656.726

Statutes implemented: ORS 656.268, 656.726

Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

436-030-0035 Determining Medically Stationary Status

(1) A worker is medically stationary in the following circumstances:

(a) **In initial injury claims.** In an initial injury claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted conditions and direct medical sequelae of accepted conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(b) **In new or omitted condition claims.** In a new or omitted condition claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted new or omitted conditions and direct medical sequelae of accepted new or omitted conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(c) **In aggravation claims.** In an aggravation claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted worsened conditions and direct medical sequelae of accepted worsened conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(d) **In occupational disease claims.** In an occupational disease claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted occupational diseases and direct medical sequela of accepted occupational diseases are either "medically stationary" or

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"medically stable" or when the provider uses other language meaning the same thing.

(2) When there is a conflict in the medical opinions as to whether a worker is medically stationary, more weight is given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and clear and concise reasoning.

(3) Where there is not a preponderance of medical opinion stating a worker is or is not medically stationary, deference will generally be given to the opinion of the attending physician. However, in cases where expert analysis is important, deference is given to the opinion of the physician with the greatest expertise in, and understanding of, the worker's medical condition.

(4) When there is a conflict as to the date upon which a worker became medically stationary, the following conditions govern the determination of the medically stationary date. The date a worker is medically stationary is the earliest date that a preponderance is established under sections (1) and (2) of this rule. The date of the examination, not the date of the report, controls the medically stationary date.

(5) The insurer may request that the attending physician or authorized nurse practitioner concur with or comment on the closing examination when the attending physician or authorized nurse practitioner arranges or refers the worker for a closing examination with another physician. When the insurer closes a claim relying on an independent medical examination to support a preponderance of opinion establishing medically stationary status, before issuing the closure the insurer must request the attending physician or authorized nurse practitioner to concur with or comment on the independent medical examination. A concurrence with another physician's report is an agreement in every particular, including the medically stationary impression and date, unless the physician expressly states to the contrary and explains the reasons for disagreement. Concurrence cannot be presumed in the absence of the attending physician's response.

(6) A worker is medically stationary on the date so specified by a physician. When a specific date is not indicated, a worker is presumed medically stationary on the date of the last examination, prior to the date of the medically stationary opinion. Physician projected medically stationary dates cannot be used to establish a medically stationary date.

(7) If the worker is incarcerated or confined in some other manner and unable to freely seek medical treatment, the insurer must arrange for closing medical examinations to be completed at the facility where the worker is located or at some other location accessible to the worker.

(8) If a worker dies and the attending physician has not established a medically stationary date, for purposes of claim closure, the medically stationary date is the date of death.

(9) Notwithstanding any other provision of this rule, a physician or nurse practitioner may not retroactively determine a worker to be medically stationary more than 60 days prior to the date of the determination, except in the case of claims that

are subject to ORS 656.268 (13). If the medically stationary date under sections (1), (4), (5), or (6) of this rule is more than 60 days prior to the date of the determination, the medically stationary date is the 60th day prior to the date of the determination.

Statutory authority: ORS 656.268(OL2022, ch. 73, sections 4 & 5), ORS 656.726
Statutes implemented: ORS 656.268 (OL2022, ch. 73, sections 4 & 5)
Hist: Amended 12/19/22 as Admin. Order 22-068, eff. 1/1/24

436-030-0036 Determining Temporary Disability

(1) Temporary disability must be determined under ORS chapter 656, OAR 436-060, and this rule, less time worked. Beginning and ending dates of each authorized period of temporary total disability and temporary partial disability must be noted on the Notice of Closure, as well as the statements "Less time worked" and "Temporary disability was determined in accordance with the law."

(2) Except as provided in section (3) of this rule and ORS 656.268(10), a worker is not entitled to any award of temporary disability for any period of time in which the worker is medically stationary.

(3) Awards of temporary disability must include the day the worker is medically stationary or the date the claim otherwise qualifies for closure, unless temporary disability is not authorized for another reason at that time.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.005, 656.160, ORS 656.210, 656.212, 656.236, 656.245, 656.262, 656.268, 656.726
Hist: Amended 11/17/11 as WCD Admin. Order 11-058, eff. 1/1/12

436-030-0038 Permanent Partial Disability

The standards developed under ORS 656.726(4) and contained in OAR 436-035 must be applied when evaluating a worker's permanent partial disability.

Statutory authority: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Statutes implemented: ORS 656.214, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Amended 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

436-030-0055 Determining Permanent Total Disability

(1) A worker is permanently and totally disabled if permanently incapacitated from regularly performing work in a suitable and gainful occupation. For the purpose of this rule and OAR 436-030-0065:

(a) **"Incapacitated from regularly performing work"** means that the worker does not have the necessary physical and mental capacity and the work skills to perform the essential functions of the job. Employment in a sheltered workshop is not considered regular employment unless this was the worker's job at the time of injury.

(b) **"Suitable occupation"** means those occupations that exist in a theoretically normal labor market, within a reasonable geographic distance, for which a worker has the training or experience, and abilities to realistically perform the job duties, with or without rehabilitation.

(c) **"Gainful occupation"** means those types of general occupations that provide wages that:

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(A) Meet the requirements in ORS 656.206(11)(a) for workers with a date of injury prior to January 1, 2006; or

(B) Meet the requirements in ORS 656.206(11)(b) for workers with a date of injury on or after January 1, 2006.

(d) **"Work skills"** means those skills acquired through experience or training that are necessary to gain and adequately perform skilled, semi-skilled or unskilled occupations. Unskilled types of general occupations require no specific skills that would be acquired through experience or training to be able to gain and adequately perform the unskilled occupation. Every worker has the necessary work skills to gain and adequately perform unskilled types of general occupations with a reasonable period of orientation.

(e) A **"reasonable geographic distance"** means either of the following unless the worker is medically precluded from commuting:

(A) The area within a 50-mile radius of the worker's place of residence at the time of:

- (i) The original injury;
- (ii) The worker's last gainful employment;
- (iii) Insurer's determination; or
- (iv) Reconsideration by the director.

(B) The area in which a reasonable and prudent uninjured and unemployed person, possessing the same physical capacities, mental capacities, work skills, and financial obligations as the worker does at the time of the rating of disability, would go to seek work.

(f) **"Types of general occupations"** means groups of jobs which actually exist in a normal labor market, and share similar vocational purpose, skills, duties, physical circumstances, goals, and mental aptitudes. It does not refer to any specific job or place of employment for which a job or job opening may exist in the future.

(g) **"Normal labor market"** means a labor market that is undistorted by such factors as local business booms and slumps or extremes of the normal cycle of economic activity, or technology trends in the long-term labor market.

(h) **"Withdrawn from the workforce"** means a worker who is not employed, is not willing to be employed, or although willing to be employed is not making reasonable efforts to find employment, unless such efforts would be futile. The receipt of retirement benefits does not establish a worker has withdrawn from the workforce.

(2) All disability that existed before the injury must be included in determining permanent total disability.

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

- (a) Prove permanent and total disability;
- (b) Be willing to seek regular and gainful employment;
- (c) Make reasonable effort to find work at a suitable and gainful occupation or actively participate in a vocational assistance program, unless medical or vocational findings,

including the residuals of the compensable injury, make such efforts futile; and

(d) Not have withdrawn from the workforce during the period for which benefits are being sought.

(4) A worker retaining some residual functional capacity and not medically permanently and totally disabled must prove:

(a) The worker has not withdrawn from the workforce for the period for which benefits are being sought;

(b) Inability to regularly perform work at a gainful and suitable occupation; and

(c) The futility of seeking work if the worker has not made reasonable work search efforts by competent written vocational testimony. Competent written vocational testimony is that which is available at the time of closure or reconsideration and comes from the opinions of persons fully certified by the State of Oregon to render vocational services.

(5) Notices of Closure and Orders on Reconsideration that grant permanent total disability must notify the worker that:

(a) The claim must be reexamined by the insurer at least once every two years, and may be reviewed more often if the insurer chooses.

(b) The insurer may require the worker to provide a sworn statement of the worker's gross annual income for the preceding year. The worker must make the statement on a form provided by the insurer in accordance with the requirements under section (6) of this rule.

(6) If asked to provide a statement under (5)(b) of this rule, the worker is allowed 30 days to respond. Such statements are subject to the following:

(a) If the worker fails to provide the requested statement, the director may suspend the worker's permanent total disability benefits. Benefits must be resumed when the statement is provided. Benefits not paid for the period the statement was withheld must be recoverable for no more than one year from the date of suspension.

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

Statutory authority: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313

Statutes implemented: ORS 656.005, ORS 656.206, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, 1999 OR Laws Chapter 313, and chapter 865, Oregon Laws 2001

Hist: Amended 6/13/22 as Admin. Order 22-056, eff. 7/1/22

436-030-0065 Review of Permanent Total Disability Awards

(1) The insurer must reexamine each permanent total disability claim at least once every two years or when requested to do so by the director to determine if the worker has materially improved, either medically or vocationally, and is capable of regularly performing work at a suitable and gainful occupation. The insurer must notify the worker and the worker's attorney if the worker is represented whenever the insurer intends to reexamine the worker's permanent total disability status. Workers who fail to cooperate with the reexamination may have benefits suspended under OAR 436-060-0095.

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(2) A worker receiving permanent total disability benefits must submit to a vocational evaluation, if requested by the director, insurer, or self-insured employer under ORS 656.206(8).

(3) Any decision by the insurer to reduce permanent total disability must be communicated in writing to the worker, and to the worker's attorney if the worker is represented, and accompanied by documentation supporting the insurer's decision. That documentation must include: medical reports, including sufficient information necessary to determine the extent of permanent partial disability, vocational and investigation reports (including visual records, if available) that demonstrate the worker's ability to regularly perform a suitable and gainful occupation, and all other applicable evidence.

(4) An award of permanent total disability for scheduled injuries before July 1, 1975, may be considered for reduction only when the insurer has evidence that the medical condition has improved.

(5) Except for section (4) of this rule, an award of permanent total disability may be reduced only when the insurer has a preponderance of evidence that the worker has materially improved, either medically or vocationally, and is regularly performing work at a suitable and gainful occupation or is currently capable of doing so. Preexisting disability must be included in redetermination of the worker's permanent total disability status.

(6) When the insurer reduces a permanent total disability claim, the insurer must, based upon sufficient information to determine the extent of permanent partial disability, issue a Notice of Closure, Permanent Total Disability Reduction ([Form 1644p](#)) that reduces the permanent total disability and awards permanent partial disability, if any.

(7) Notices of Closure reducing permanent total disability are appealable to the board.

(8) If a worker is receiving permanent total disability benefits and sustains a new compensable injury, the worker is eligible for additional benefits for the new compensable injury, except that the worker's eligibility for compensation for the new compensable injury is limited to medical benefits under ORS 656.245 and permanent partial disability benefits for impairment, as determined in the manner set forth in ORS 656.214(2).

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.206, 656.214, 656.268, 656.283, 656.319, 656.325, 656.331, 656.726
Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

436-030-0066 Review of Prior Permanent Partial Disability Awards

For claims having a date of injury prior to January 1, 2005, which involve unscheduled body parts, areas, or systems as defined by OAR 436-035-0005, and all claims with dates of injury on or after January 1, 2005, an award of permanent partial disability is subject to periodic examination and adjustment under ORS 656.268 and 656.325 and in accordance with the following conditions:

(1) Requests for review and adjustment must be made in writing to the division.

(2) The party requesting review of permanent disability must send a copy of the request to all involved parties at the time the request is made. The worker may submit any information in rebuttal.

(3) All pertinent medical, vocational, and other applicable evidence must be submitted with the request, including sufficient information to determine the extent of permanent partial disability. The request must state the basis for the request and provide supporting evidence. If the director finds that the worker has failed to accept treatment as provided in this rule, the director will make any necessary adjustments allowed under OAR 436-035.

(4) The basis for the request for adjustment in the permanent disability award must be asserted to be failure of the worker to make a reasonable effort to reduce the disability.

Statutory authority: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Statutes implemented: ORS 656.325, ORS 656.331, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

436-030-0115 Reconsideration of Notices of Closure

(1) A worker, insurer, or beneficiary may request reconsideration of a Notice of Closure as provided in ORS 656.268.

(2) Under ORS 656.218(4), a worker's estate may request reconsideration of a Notice of Closure if the worker dies before filing a request and there are no persons entitled to receive death benefits under ORS 656.204.

(3) A request for reconsideration may be made by mailing, phoning, or delivering the request to the director within the statutory appeal period as defined in OAR 436-030-0005 and 436-030-0145(1). The reconsideration proceeding begins as described in OAR 436-030-0145(2).

(4) For the purpose of these rules, "reconsideration proceeding" means the procedure established to reconsider a Notice of Closure and does not include personal appearances by any of the parties to the claim or their representatives, unless requested by the director. All information to correct or clarify the record and any medical evidence regarding the worker's condition as of the time of claim closure that should have been but was not submitted by the attending physician or authorized nurse practitioner at the time of claim closure and all supporting documentation must be presented during the reconsideration proceeding. When the reconsideration proceeding is postponed under OAR 436-030-0165(9) because the worker's condition is not medically stationary, medical evidence submitted may address the worker's condition after claim closure as long as the evidence satisfies the conditions of OAR 436-030-0145(3).

(5) All parties have an opportunity to submit documents to the record regarding the worker's status at the time of claim closure. Other factual information and written argument may be submitted for incorporation into the record under ORS 656.268(6) within the time frames outlined in OAR 436-030-

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0145. Such information may include, but is not limited to, responses to the documentation and written arguments, written statements, and sworn affidavits from the parties.

(6) The worker may submit a deposition to the reconsideration record subject to ORS 656.268(6) and the following:

(a) The deposition must be limited to the testimony and cross-examination of a worker about the worker's condition at the time of claim closure.

(b) The deposition must be arranged by the worker and held during the reconsideration proceeding time frame unless a good cause reason is established. If a good cause reason is established, the time frame for holding the deposition may be extended but may not extend beyond 30 days from the date of the Order on Reconsideration. The deposition must be held at a time and place that permits the insurer or self-insured employer the opportunity to cross-examine the worker.

(c) The insurer or self-insured employer must, within 30 days of receiving a bill for the deposition, pay the fee of the court reporter, the costs for the original transcript and one copy for each party, and the cost of necessary interpreter services. An original transcript of the deposition must be sent to the department and each party must be sent a copy of the transcript.

(d) If the transcript is not completed and presented to the department prior to the deadline for issuing an Order on Reconsideration, the Order on Reconsideration may not be postponed to receive a deposition under this rule and the order will be issued based on the evidence in the record. However, the transcript may be received as evidence at a hearing for an appeal of the Order on Reconsideration.

(7) Only one reconsideration proceeding may be completed on each Notice of Closure and the director will review those issues raised by the parties and the requirements under ORS 656.268(1). Once the reconsideration proceeding is initiated, issues must be raised and further evidence submitted within the time frames allowed for processing the reconsideration request. When the director requires additional information to complete the record, the reconsideration proceeding may be postponed under ORS 656.268(6).

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.218, 656.268
Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

436-030-0125 Reconsideration Form and Format

A request for reconsideration may be in the form and format the director provides in [Bulletin 227](#). A reconsideration request should include at least the following:

- (1) Worker's name;
- (2) Date of injury;
- (3) Date of the closure being appealed;
- (4) Any specific issues regarding the Notice of Closure;
- (5) The name of the worker's attorney, if any;
- (6) The name of the insurer's attorney, if any;
- (7) If the request is made by a beneficiary of the worker or the worker's estate, the identity and name of the requester, the

name of the requester's attorney, if any, and contact information;

(8) Any special language needs;

(9) Whether there is disagreement with the specific impairment findings used to determine permanent disability at the time of claim closure;

(10) Any information and documentation deemed necessary to correct or clarify any part of the claim record believed to be erroneous; and

(11) Any medical evidence that should have been but was not submitted at the time of the claim closure including clarification or correction of the medical record based on the examination(s) at, before, or pertaining to claim closure.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.268
Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

436-030-0135 Reconsideration Procedure

(1) Within 14 days from the date of the director's notice of the start of the reconsideration proceeding, the insurer must provide, in chronological order by document date, all documents pertaining to the claim including, but not limited to, the complete medical record and all official action and notices on the claim, to:

(a) The director;

(b) The worker or the worker's attorney;

(c) The beneficiary or beneficiary's attorney, if the request was made by the beneficiary; and

(d) The estate or estate's attorney, if the request was made by the worker's estate.

(2) The request for reconsideration and all other information submitted to the director by any party during the reconsideration process must be copied to all interested parties. Failure to comply with this requirement may result in the information not being included as part of the record on reconsideration.

(3) The director may issue an order rescinding a Notice of Closure if any of the following apply:

(a) The claim was not closed as prescribed by rule.

(b) In a claim closed under ORS 656.268(1)(a), the worker was not medically stationary at the time of claim closure.

(c) In a claim closed under ORS 656.268(1)(a) or 656.268(1)(b), the claim was closed without sufficient information to determine the extent of permanent disability under OAR 436-030-0020(2).

(d) In a claim closed under ORS 656.268(1)(c), the claim was not closed in strict compliance with OAR 436-030-0034.

(4) When a worker has requested and cashed a lump sum payment, under ORS 656.230, of an award granted by a Notice of Closure, the director will not consider the adequacy of that award in a reconsideration proceeding.

(5) When a new condition is accepted after a prior claim closure, and the newly accepted condition is subsequently closed, the director and the parties may mutually agree to

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consolidate requests for review of the closures into one reconsideration proceeding, provided the director has jurisdiction and neither of the closures have become final by operation of law.

(6) The reconsideration order may affirm, reduce, or increase the compensation awarded by the Notice of Closure.

(7) After the reconsideration order has been issued and before the end of the 30-day appeal period for the order on reconsideration, if a party discovers that additional documents were not provided by the opposing party in accordance with this rule, the Order on Reconsideration may be abated and withdrawn to give the party an opportunity to respond to the new information.

Statutory authority: ORS 656.726

Statutes implemented: ORS 656.268 (2015 Or Laws, Ch. 144)

Hist: Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15

436-030-0145 Reconsideration Time Frames and Postponements

(1) When appealing a Notice of Closure for claims that are medically stationary or that statutorily qualified for closure on or after June 7, 1995, a request for reconsideration must be mailed within:

(a) Sixty (60) days of the mailing date of the Notice of Closure for a worker's request.

(b) Seven (7) days of the mailing date of the Notice of Closure for an insurer's request. An insurer's request for reconsideration is limited to the findings used to rate impairment.

(c) Sixty (60) days of the mailing date of the Notice of Closure for a beneficiary's request if the Notice of Closure was mailed to the beneficiary under ORS 656.268(5)(b).

(d) One year of the date the Notice of Closure was mailed to the estate of the worker if the Notice of Closure was not mailed to the beneficiary under ORS 656.268(5)(b).

(2) The reconsideration proceeding begins upon:

(a) The director's receipt of the worker's, estate's, or beneficiary's request for reconsideration, if the insurer has not previously requested reconsideration consistent with (1)(b) of this rule; or

(b) The 61st day after the closure of the claim, if the insurer has requested reconsideration consistent with (1)(b) of this rule, unless the director receives, within the appeal time frames in section (1) of this rule, a request for reconsideration or a statement by the worker, estate, beneficiary, or representative instructing the director to start the reconsideration proceeding.

(3) Fourteen days from the date of the director's notice of the start of the reconsideration proceeding, the reconsideration request and all other appropriate information submitted by the parties will become part of the record used in the reconsideration proceeding. Requests for a medical arbiter panel must be submitted within this time frame.

(a) Evidence received or issues raised subsequent to the 14-day deadline will be considered in the reconsideration proceeding to the extent practicable.

(b) Upon review of the record the director may request, under ORS 656.268(6), any additional information deemed necessary for the reconsideration and set appropriate time frames for response.

(c) Except as provided in sections (4), (5), and (6) of this rule, the director will, within 18 working days from the date the reconsideration proceeding begins, either mail an Order on Reconsideration or notify the parties that the reconsideration proceeding is postponed for not more than 60 additional days as provided under ORS 656.268(6).

(4) The director may delay the reconsideration proceeding and toll the reconsideration timeline for up to 45 days when both parties provide written notice to the director requesting the delay for settlement negotiations. The notice is only effective if the director receives it before the 18th working day after the reconsideration proceeding begins.

(a) This delay of the reconsideration proceeding expires:

(A) When the director receives a written request from either party to resume the reconsideration proceeding;

(B) When the director receives a copy of the approved settlement resolving some or all of the issues raised at the reconsideration proceeding; or

(C) On the next calendar day following the authorized delay period.

(b) The director may authorize only one delay period for each reconsideration proceeding.

(5) When the director provides notice the worker failed to attend the medical arbiter examination without good cause or failed to cooperate with the arbiter examination and suspends benefits under ORS 656.268(8), the reconsideration proceeding will be postponed for up to 60 additional days from the date the director determines and provides notice, to allow completion of the arbiter process.

(6) The reconsideration proceeding may be stayed under the following circumstances:

(a) The parties consent to deferring the reconsideration proceeding, under ORS 656.268(8)(i)(B), when the medical arbiter examination is not medically appropriate because the worker's medical condition is not stationary; or

(b) When a claim disposition agreement (CDA) is filed. If this occurs, the reconsideration proceeding is stayed until the CDA is either approved or set aside.

(7) If the director fails to mail an Order on Reconsideration or a Notice of Postponement under the time frames specified in ORS 656.268, the reconsideration request is automatically deemed denied. The parties may immediately thereafter proceed as though the director had issued an Order on Reconsideration affirming the Notice of Closure.

(8) Notwithstanding any other provision regarding the reconsideration proceeding, the director may extend nonstatutory time frames to allow the parties sufficient time to present evidence and address their issues and concerns.

Statutory authority: ORS 656.726

Statutes implemented: ORS 656.268

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436-030-0155 Reconsideration Record

(1) The record for the reconsideration proceeding includes all documents and other material relied upon in issuing the Order on Reconsideration as well as any additional material submitted by the parties, but not considered in the reconsideration proceeding.

(a) The record is maintained by the division and consists of all documents and material documented as received by the director prior to the issuance of the Order on Reconsideration, unless the document is an exact duplicate of what is in the file then the director is not required to retain the duplicate document.

(b) The insurer or self-insured employer may not send billing information and duplicate documents to the department, unless specifically requested by the director.

(c) Evidence stored by the parties on audio media and submitted as part of the reconsideration record may only be submitted in transcribed form.

(2) Except as noted in this section, the medical record submitted by the director for arbiter review will consist of all medical documents and medical material produced by the claim under reconsideration, provided the information is allowable under ORS 656.268.

(3) The director will send non-medical information, nursing notes, or physical therapy treatment notes to the arbiter if:

(a) A party requests the director to submit those specific materials;

(b) The party identifies and provides the director with specific dates of those materials requested to be submitted; and

(c) The materials otherwise meet the requirements of this rule.

(4) When any surveillance video obtained prior to closure has been submitted to a physician involved in the evaluation or treatment of the worker, it must be provided for arbiter review.

(a) Surveillance video provided for arbiter review must have been reviewed prior to claim closure by a physician involved in the evaluation or treatment of the worker.

(b) All written materials previously forwarded to a physician along with the surveillance video, such as investigator field notes, summary or narrative reports, and cover letters, must also be submitted.

(c) Surveillance video must be labeled according to the date and total time of the recording.

(5) When reconsideration is requested, the insurer is required to provide the director and the other parties with a copy of all documents contained in the record at claim closure. For cases involving a health care provider who must meet criteria other than those of an attending physician or who practices under contract with a managed care organization, the insurer must provide documentation of the health care provider's authority to act as an attending physician. Responses of the parties to the medical arbiter report will be included in the record if received prior to completion of the reconsideration proceeding.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.268

Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

436-030-0165 Medical Arbiter Examination Process

(1) The director will select a medical arbiter physician or a panel of physicians in accordance with ORS 656.268(8).

(a) For the purpose of this rule, a "panel" of physicians is defined as two or three medical arbiters.

(b) When a panel medical arbiter examination is requested, the director will generally appoint three medical arbiters. The director may consider the following criteria when determining whether to appoint two medical arbiters instead:

(A) The location of the worker;

(B) The specialties of the doctors needed for the medical arbiter examination; and

(C) The time frame for completing the reconsideration process.

(c) Any party that objects to a physician on the basis that the physician is not qualified under ORS 656.005(12)(b) must notify the director of the specific objection before the examination. If the director determines that the physician is not qualified to be a medical arbiter on the specific case, an examination will be scheduled with a different physician.

(d) When the worker resides outside the state of Oregon, a medical arbiter examination may be scheduled out-of-state with a physician who is licensed within that state to provide medical services in the same manner as required by ORS 656.268(8).

(e) Arbiters or panel members will not include any health care provider whose examination or treatment is the subject of the review.

(f) The insurer must pay all costs related to the completion of the medical arbiter process in this rule. These costs may include, but are not limited to, costs for child care, travel, meals, lodging, and an amount equivalent to the worker's net lost wages for the period during which it is necessary to be absent from work to attend the medical examination if the worker does not receive benefits under ORS 656.210(4) during the period of absence.

(2) If the director determines there are enough appropriate physicians available to create a list of possible arbiters and it is practicable, each party will be given the opportunity to agree on a physician and to remove one physician from the list through the process described below:

(a) The director will send the list to the parties electronically or by overnight mail.

(b) If the parties agree on a physician, every party must send a signed, written notice of that choice to the director.

(c) A party can remove a physician from the list, even when the parties have agreed on a physician to conduct the exam, by submitting a signed, written notice of that choice to the director.

(d) To be effective, the written notice of agreement on or rejection of a physician must be received by the director within three working days of the date the director sent the list.

(3) The worker's disability benefits will be suspended when the director determines the worker failed to attend or cooperate

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with the medical arbiter examination, unless the worker establishes a "good cause" reason for missing the examination or for not cooperating with the arbiter. The worker must call the director within 24 hours of the missed examination to provide any "good cause" reason.

(a) Notice of the examination will be considered adequate notice if the appointment letter is mailed to the last known address of the worker and to the worker's attorney, if the worker is represented.

(b) For the purposes of this rule, non-cooperation includes, but is not limited to, refusal to complete any reasonable action necessary to evaluate the worker's impairment. However, it does not include circumstances such as a worker's inability to carry out any part of the examination due to excessive pain or when the physician reports the findings as medically invalid.

(c) Failure of the worker to respond within the time frames outlined in statute for completion of the reconsideration proceeding may be considered a failure to establish "good cause."

(4) If a worker misses the medical arbiter examination, the director will determine whether or not there was a "good cause" reason for missing the examination.

(5) Upon determination that there was not a "good cause" reason for missing the examination, or that the worker failed to cooperate with the arbiter, the worker's disability benefits will be suspended and the reconsideration proceeding postponed for up to an additional 60 days.

(6) The suspension will be lifted if any of the following occur during the additional 60-day postponement period:

(a) The worker establishes a "good cause" reason for missing or failing to cooperate with the examination;

(b) The worker withdraws the request for reconsideration; or

(c) The worker attends and cooperates with a rescheduled arbiter examination.

(7) If none of the events that end the suspension under section (6) of this rule occur before the expiration of the 60-day additional postponement, the suspension of benefits will remain in effect.

(8) The medical arbiter or panel of medical arbiters must perform a record review or examine the worker as requested by the director and perform such tests as may be reasonable and necessary to establish the worker's impairment.

(a) The parties must submit to the director any issues they wish the medical arbiter or panel of medical arbiters to address within 14 days of the date of the director's notice of the start of the reconsideration proceeding. The parties may not submit issues directly to the medical arbiter or panel of medical arbiters. The medical arbiter or panel of medical arbiters will only consider issues appropriate to the reconsideration proceeding.

(b) The report of the medical arbiter or panel of medical arbiters must address all questions raised by the director.

(c) The medical arbiter will provide copies of the arbiter report to the director, the worker or the worker's attorney, and the insurer within five working days after completion of the arbiter review. The cost of providing copies of such additional reports must be reimbursed according to OAR 436-009-0060 and must be paid by the insurer.

(9) When a worker's medical condition prevents the worker from fully participating in a medical arbiter examination that must be conducted to determine findings of impairment, the director may send a letter to the parties requesting consent to defer the reconsideration proceeding. The medical condition that prevents the worker from participating in the medical arbiter examination does not need to be related to the work injury.

(a) If the parties agree to the deferral, the reconsideration proceeding will be deferred until the medical record reflects the worker's condition has stabilized sufficiently to allow for examination to obtain the impairment findings. The parties must notify the director when it is appropriate to schedule the medical arbiter examination and provide the necessary medical records when requested. Interim medical information that may be helpful to the director and the medical arbiter in assessing and describing the worker's impairment may be submitted at the time the parties notify the director that the medical arbiter examination can be scheduled. The director will determine whether the interim medical information is consistent with the provisions of ORS 656.268(6) and (8).

(b) If deferral is not appropriate, at the director's discretion either a medical arbiter examination or a medical arbiter record review may be obtained, or the director may issue an Order on Reconsideration based on the record available at claim closure and other evidence submitted in accordance with ORS 656.268(6).

(10) All costs related to record review, examinations, tests, and reports of the medical arbiter must be billed and paid under OAR 436-009-0010, 436-009-0030, 436-009-0040, and 436-009-0060.

(11) When requested by the board, the director may schedule a medical arbiter examination for a worker who has appealed a Notice of Closure rescinding permanent total disability benefits under ORS 656.206.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.268 and ORS 656.325
Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

436-030-0175 Fees and Penalties within the Reconsideration Proceeding

(1) An insurer failing to provide information or documentation as set forth in OAR 436-030-0135, 436-030-0145, 436-030-0155 and 436-030-0165 may be assessed civil penalties under OAR 436-030-0580. Failure to comply with the requirements set forth in OAR 436-030-0135, 436-030-0145, 436-030-0155, and 436-030-0165 may also be grounds for extending the reconsideration proceeding under ORS 656.268(6).

(2) If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent

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disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer will be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent disability compensation. Penalties will not be assessed if an increase in compensation results from one of the following:

(a) An order issued by the director that addresses the extent of the worker's permanent disability that is not based on the standards adopted under ORS 656.726(4)(f);

(b) New information is obtained through a medical arbiter examination, for claims with medically stationary dates or statutory closure dates on or after June 7, 1995; or

(c) Information that the insurer or self-insured employer demonstrates they could not reasonably have known at the time of claim closure.

(3) For the purpose of section (2) of this rule, a worker who receives a total sum of 64 degrees of scheduled or unscheduled disability or a combination thereof, will be found to be at least 20 percent disabled.

For example: A worker who receives 20 percent disability of a great toe (3.6 degrees) is not considered 20 percent permanently disabled because the great toe is only a portion of the whole person. A worker who is 100 percent permanently disabled is entitled to 320 degrees of disability. A worker who receives 64 degrees (20 percent of 320 degrees), whether scheduled, unscheduled or a combination thereof, will be considered the equivalent of at least 20 percent permanently disabled for the purposes of this rule.

(4) Attorney fees under ORS 656.268(6)(c) are addressed in OAR 436-001-0432. Attorney fees under ORS 656.383(1) are addressed in OAR 436-001-0438.

Statutory authority: ORS 656.726

Statutes implemented: ORS 656.268, 656.383, 656.745

Hist: Amended 7/5/22 as WCD Admin. Order 22-062, eff. 9/1/22

436-030-0185 Reconsideration: Settlements and Withdrawals

(1) Contested matters arising out of a claim closure may be resolved by mutual agreement of the parties at any time after the claim has been closed under ORS 656.268 but before that claim closure has become final by operation of law. If the parties have reached such an agreement prior to the completion of the reconsideration proceeding, the parties must submit the stipulation agreement to the director for approval as part of the reconsideration proceeding. The stipulation submitted for review at the reconsideration proceeding must:

(a) Address only issues that pertain to a claim closure and cannot include any issues of compensability; and

(b) List the body part for which any award is made and recite all disability awarded in both degrees and percent of loss as appropriate based on date of injury when permanent partial disability is part of the stipulated agreement. In the event there is any inconsistency between the stated degrees and percent of loss awarded in any stipulated agreement for claims with dates

of injury prior to January 1, 2005, the stated percent of loss will control.

(2) The director will review the stipulation and issue an order approving or denying the stipulation. Stipulations approved by the director cannot be appealed.

(3) When the stipulated agreement does not expressly resolve all issues relating to the claim closure, the Order on Reconsideration will include the stipulation, as well as a substantive determination of all remaining issues. In these claims, the 18 working day time frame may be postponed in the same manner as any reconsideration proceeding.

(4) If the stipulation is not approved, the reconsideration proceeding will be postponed to allow the parties to:

(a) Address the disapproval, or

(b) Request that the director issue an Order on Reconsideration addressing the substantive issues.

(5) When the parties desire to enter into a stipulated agreement to resolve disputed issues relating to the claim closure, but are unable to reach an agreement, the parties may request the assistance of the director to mediate an agreement.

(6) When the parties desire to enter into a stipulated agreement that addresses all matters being reconsidered as well as issues not before the reconsideration proceeding, and the parties do not want a reconsideration on the merits of the claim closure, they may advise the director of their resolution and request the director enter an Order on Reconsideration affirming the Notice of Closure. The request for an affirming order must be made prior to the date an Order on Reconsideration is issued and in accordance with the following procedure.

(a) A written request for an affirming reconsideration order must:

(A) Be made by certified mail;

(B) Be signed by both parties or their representatives;

(C) State that the parties waive their right to an arbiter review and that all matters subject to the mandatory reconsideration process have been resolved; and

(D) Be accompanied by a copy of the proposed stipulated agreement.

(b) After the affirming Order on Reconsideration has been issued, the parties will submit their stipulation to an administrative law judge of the board for approval in accordance with ORS 656.289 and the board's rules.

(c) An Order on Reconsideration issued under this rule is final and is subject to review under ORS 656.283.

(d) This provision does not apply to claims disposition agreements filed under ORS 656.236.

(7) A worker requesting a reconsideration may withdraw the request for reconsideration without agreement of the other parties only if:

(a) No additional information has been submitted by the other parties;

(b) No medical arbiter examination has occurred, and

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(c) The insurer has not requested reconsideration under OAR 436-030-0145.

(8) Notwithstanding (7) above, if additional information has been submitted by the other party(ies), a medical arbiter examination has occurred, or the insurer has requested reconsideration, the reconsideration request will not be dismissed unless all parties agree to the withdrawal.

(9) If the insurer has requested reconsideration, either the worker or the insurer may initiate the withdrawal request, but both must agree to the withdrawal.

Statutory authority: ORS 656.726

Statutes implemented: ORS 656.268

Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

436-030-0575 Audits

(1) Notices of Closure and supporting documentation including, but not limited to, the Notice of Closure Worksheet ([Form 2807](#)) upon which the Notice of Closure is based, will be subject to periodic audit by the director. Supporting documentation and records must be maintained in accordance with OAR 436-050.

(2) The insurer or self-insured employer is required to provide the director, within seven days of the director's request, any data the director identifies as necessary to determine the impact of legislative changes on permanent partial disability awards.

Statutory authority: ORS 656.268 and ORS 656.726

Statutes implemented: ORS 656.268, ORS 656.455, and ORS 656.726

Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

SMC (repeal of ORS 656.750)– ORS 183.335(7), filed and effective 6/18/24

436-030-0580 Penalties and Sanctions

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

(2) An insurer or health care provider failing to meet the requirements set forth in these rules may be assessed a civil penalty.

(3) Under OAR 436-010-0340, the director may impose sanctions for any health care provider where the insurer can provide sufficient documentation to substantiate lack of cooperation. The medical service provider will be sent a warning letter about the reporting requirements and possible penalties. Failure by the health care provider to submit the requested information within the specified period may result in civil penalties.

(4) Sufficient documentation to substantiate lack of cooperation by the health care provider includes:

- (a) Copies of letters to the health care provider;
- (b) Memos to the claim file of follow-up phone calls or the lack of response;
- (c) Letters from the health care provider indicating a lack of cooperation; or
- (d) Medical reports received by the insurer, after adequate instruction by the insurer or the director, which do not supply the requested information or which supply information that is

not consistent with the Disability Rating Standards in OAR 436-035.

Statutory authority: ORS 656.268, 656.726

Statutes implemented: ORS 656.268, 656.726, 656.745

Hist: Amended 12/1/2009 as WCD Admin. Order 09-056 eff. 1/1/2010

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DISABILITY RATING STANDARDS**

**Administrative
Order No.
22-064**

**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 035
DISABILITY RATING STANDARDS**

Effective Dec. 4, 2022

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436-035-0001 Authority for Rules

These rules are promulgated under the Director's authority contained in ORS 656.726(4).

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 1/14/03 as WCD Admin. Order 03-050, eff. 2/1/03

436-035-0002 Purpose of Rules

These rules establish standards for rating permanent disability under the Workers' Compensation Act. These standards are written to reflect the criteria for rating outlined in ORS chapter 656 and assign values for disabilities that are applied consistently at all levels of the workers' compensation award and appeal process.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.012, 656.210, 656.212, 656.214, 656.222, 656.225, 656.245, 656.262, 656.267, 656.268, 656.273, 656.726, 656.790

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0003 Applicability of Rules

(1) These rules apply to the rating of permanent disability under ORS chapter 656 and to all claims closed on or after the effective date of these rules for workers medically stationary on or after June 7, 1995.

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(2) The rules adopted by WCD Administrative Order 93-056 apply to the rating of permanent disability for workers medically stationary on or after July 1, 1990 but before June 7, 1995, except as otherwise provided in 1995 Oregon Laws, chapter 332.

(3) The rules adopted by WCD Administrative Order 6-1988 apply to the rating of permanent disability for workers medically stationary before July 1, 1990, except as otherwise provided in 1995 Oregon Laws, chapter 332.

(4) For the purpose of reconsideration of claim closure under ORS 656.268, the rules in effect on the date of issuance of the appealed notice of closure apply to the rating of permanent disability for workers medically stationary after July 1, 1990, except as otherwise provided in 1995 Oregon Laws, chapter 332.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.273, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

Amended 4/10/17 as AO 17-054 (temporary/expired), eff. 4/11/17 through 10/7/17

436-035-0005 Definitions

As used in OAR 436-035-0001 through 436-035-0500, unless the context requires otherwise:

(1) **"Activities of daily living (ADL)"** include, but are not limited to, the following personal activities required by an individual for continued well-being: eating/nutrition; self-care and personal hygiene; communication and cognitive functions; and physical activity, e.g., standing, walking, kneeling, hand functions, etc.

(2) **"Ankylosis"** means a bony fusion, fibrous union, or arthrodesis of a joint. Ankylosis does not include pseudarthrosis or articular arthropathies.

(3) **"Date of issuance"** means the mailing date of a notice of closure or Order on Reconsideration under ORS 656.268 and ORS 656.283(6).

(4) **"Dictionary of Occupational Titles"** or (DOT) means the publication of the same name by the U.S. Department of Labor, Fourth Edition Revised 1991.

(5) **"Direct medical sequela"** means a condition that is clearly established medically and originates or stems from an accepted condition. For example: The accepted condition is low back strain with herniated disc at L4-5. The worker develops permanent weakness in the leg and foot due to the accepted condition. The weakness is considered a "direct medical sequela".

(6) **"Earning capacity"** means impairment as modified by age, education, and adaptability.

(7) **"Irreversible findings"** for the purposes of these rules are:

- (a) Arm
 - (A) Arm angulation
 - (B) Radial head resection
 - (C) Shortening
- (b) Eye
 - (A) Enucleation

(B) Lens implant

(C) Lensectomy

(c) Gonadal: Loss of gonads resulting in absence of, or an abnormally high, hormone level.

(d) Hand

(A) Carpal bone fusion

(B) Carpal bone removal

(e) Kidney: Nephrectomy

(f) Leg

(A) Knee angulation

(B) Length discrepancy

(C) Meniscectomy

(D) Patellectomy

(g) Lung: Lobectomy

(h) Shoulder

(A) Acromionectomy

(B) Clavicle resection

(i) Spine

(A) Compression, spinous process, pedicle, laminae, articular process, odontoid process, and transverse process fractures

(B) Discectomy

(C) Laminectomy

(j) Spleen: Splenectomy

(k) Urinary tract diversion

(A) Cutaneous ureterostomy without intubation

(B) Nephrostomy or intubated ureterostomy

(C) Uretero-Intestinal

(L) Other

(A) Amputations/resections

(B) Ankylosed/fused joints

(C) Displaced pelvic fracture ("healed" with displacement)

(D) Loss of opposition

(E) Organ transplants (heart, lung, liver, kidney)

(F) Prosthetic joint replacements

(8) **"Medical arbiter"** means a physician under ORS 656.005(12)(b)(A) appointed by the director under OAR 436-010-0330.

(9) **"Offset"** means to reduce a current permanent partial disability award, or portions of the award, by a prior Oregon workers' compensation permanent partial disability award from a different claim.

(10) **"Physician's release"** means written notification, provided by the attending physician to the worker and the worker's employer or insurer, releasing the worker to work and describing any limitations the worker has.

(11) **"Pre-existing condition"**

(a) **Injury claims.** For all industrial injury claims with a date of injury on or after Jan. 1, 2002, "pre-existing condition" means a condition that:

- (A) Is arthritis or an arthritic condition; or
- (B) Was treated or diagnosed before:
- (i) The initial injury in a claim for an initial injury or omitted condition;
- (ii) The onset of the new medical condition in a claim for a new medical condition; or
- (iii) The onset of the worsened condition in a claim for an aggravation under ORS 656.273 or 656.278.
- (b) **Occupational disease claims.** For all occupational disease claims with a date of injury on or after Jan. 1, 2002, "pre-existing condition" means a condition that precedes the onset of the claimed occupational disease, or precedes a claim for worsening under ORS 656.273 or 656.278.
- (12) **"Preponderance of medical evidence" or "opinion"** does not necessarily mean the opinion supported by the greater number of documents or greater number of concurrences; rather it means the more probative and more reliable medical opinion based upon factors including, but not limited to, one or more of the following: (a) The most accurate history,
- (b) The most objective findings,
- (c) Sound medical principles, or
- (d) Clear and concise reasoning.
- (13) **"Redetermination"** means a re-evaluation of disability under ORS 656.267, 656.268(10), 656.273, and 656.325.
- (14) **"Regular work"** means the job the worker held at the time of injury.
- (15) **"Scheduled disability"** means a compensable permanent loss of use or function that results from injuries to those body parts listed in ORS 656.214(3)(a) through (5).
- (16) **"Social-vocational factors"** means age, education, and adaptability factors under ORS 656.726(4)(f).
- (17) **"Superimposed condition"** means a condition that arises after the compensable injury or disease that contributes to the worker's overall disability or need for treatment but is not the result of the original injury or disease. Disability from a superimposed condition is not rated. For example: The compensable injury results in a low back strain. Two months after the injury, the worker becomes pregnant (non-work related). The pregnancy is considered a "superimposed condition."
- (18) **"Unscheduled disability"** means permanent loss of earning capacity as a result of a compensable injury, as described in these rules and arising from those losses under OAR 436-035-0330 through 436-035-0450.
- (19) **"Work disability,"** for the purposes of determining permanent disability, means impairment as modified by age, education, and adaptability to perform the job at which the worker was injured.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.267, 656.268, 656.273, 656.325, 656.726
Hist.: Amended 1/29/15 as WCD Admin. Order 15-053, eff. 3/1/15

436-035-0006 Determination of Benefits for Disability Caused by the Compensable Injury

(1) **In initial injury claims.** In an initial injury claim, permanent disability caused by the compensable injury includes disability caused by:

- (a) An accepted condition; or
- (b) A direct medical sequela of an accepted condition.

(2) **In new or omitted condition claims.** In a new or omitted condition claim, permanent disability caused by the compensable injury includes disability caused by:

- (a) An accepted new or omitted condition; or
- (b) A direct medical sequela of an accepted new or omitted condition.

(3) **In aggravation claims.** In an aggravation claim, permanent disability caused by the compensable injury includes disability caused by:

- (a) An accepted worsened condition; or
- (b) A direct medical sequela of an accepted worsened condition.

(4) **In occupational disease claims.** In an occupational disease claim, permanent disability caused by the compensable injury includes disability caused by:

- (a) An accepted occupational disease; or
- (b) A direct medical sequela of an accepted occupational disease.

Stat. Auth.: ORS 656.726

Stats. Impltd.: ORS 656.005, 656.214, 656.225, 656.268, 656.726, 656.802

Hist: Amended 9/7/17 as Admin. Order 17-057, eff. 10/8/17

436-035-0007 General Principles

(1) Eligibility for impairment.

(a) **Eligibility, generally.** A worker is eligible for an award for impairment if:

- (A) The worker suffers permanent loss of use or function of a body part or system;
- (B) The loss is established by a preponderance of medical evidence based upon objective findings of impairment; and
- (C) The loss is due to the compensable injury.

(b) **Apportionment.** A worker's award for impairment is limited to the amount of impairment caused by the compensable injury subject to the following:

(A) If the loss of use or function of a body part or system is entirely caused by the compensable injury, the worker is eligible for the full award provided for the loss under the rating standards in this division of rules.

(B) If the loss of use or function of a body part or system is partly caused by the compensable injury, the following provisions apply:

(i) The worker is eligible for an award for impairment for:

(I) The portion of the loss due to the compensable injury;

(II) The portion of the loss caused by a condition that does not qualify as a pre-existing condition but that existed before the initial injury in an initial injury or omitted condition claim,

before the onset of the accepted new medical condition in a new condition claim, or before the onset of the accepted worsened condition in an aggravation claim; and

(III) The portion of the loss caused by a condition that qualifies as a pre-existing condition, but is not part of a denial of a combined condition.

(ii) The worker is not eligible for an award for impairment for the portion of the loss caused by:

(I) A superimposed condition;

(II) A pre-existing condition, as defined by OAR 436-035-0005(11) and ORS 656.005(24), if the pre-existing condition was accepted as part of a combined condition and there is a subsequent denial of the combined condition, unless the pre-existing condition is otherwise compensable under ORS 656.225; or

(III) A combined condition denied in its entirety.

(C) If the loss of use or function of a body part or system is not caused in any part by the compensable injury, the loss is not due to the compensable injury and the worker is not eligible for an award for impairment.

(2) **Eligibility for work disability.** An award for impairment is modified by the factors of age, education, and adaptability if the worker is eligible for an award for work disability. A worker is eligible for an award for work disability if:

(a) The worker is eligible for an award for impairment;

(b) An attending physician or authorized nurse practitioner has not released the worker to the job held at the time of injury;

(c) The worker has not returned to the job held at the time of injury; and

(d) The worker is unable to return to the job held at the time of injury because the worker has a permanent work restriction that is caused in any part by the compensable injury.

(3) When a new or omitted medical condition has been accepted since the last arrangement of compensation, the extent of permanent disability must be redetermined.

(a) Redetermination includes the rating of the new impairment attributed to the accepted new or omitted medical condition and the reevaluation of the worker's social-vocational factors. The following applies to claims with a date of injury on or after Jan. 1, 2005:

(A) When there is a previous work disability award and there is no change in the worker's restrictions but impairment values increase, work disability must be awarded based on the additional impairment.

(B) When there is not a previous work disability award but the accepted new or omitted medical condition creates restrictions that do not allow the worker to return to regular work, the work disability must be awarded based on any previous and current impairment values.

(b) When performing a redetermination of the extent of permanent disability under this section, the amount of impairment caused by a condition other than the accepted new or omitted condition is not re-evaluated and is given the same

impairment value as established at the last arrangement of compensation.

(4) When a worker has a prior award of permanent disability under Oregon workers' compensation law, disability is determined under OAR 436-035-0015 (offset) for purposes of determining disability only as it pertains to multiple Oregon workers' compensation claims.

(5) Establishing impairment.

(a) Impairment is established based on objective findings of the attending physician under ORS 656.245(2)(b)(C) and OAR 436-010-0280.

(b) On reconsideration, when a medical arbiter is used, impairment is established based on objective findings of the medical arbiter, except where a preponderance of the medical evidence demonstrates that different findings by the attending physician are more accurate and should be used.

(c) A determination that loss of use or function of a body part or system is due to the compensable injury is a finding regarding the worker's impairment.

(d) A determination that loss of use or function of a body part or system is due to the compensable injury must be established by the attending physician or medical arbiter.

(6) Objective findings made by a consulting physician or other medical providers (e.g., occupational or physical therapists) at the time of closure may be used to determine impairment if the worker's attending physician concurs with the findings.

(7) If there is no measurable impairment under these rules, no award of permanent partial disability is allowed.

(8) Pain is considered in the impairment values in these rules to the extent that it results in valid measurable impairment. For example: The medical provider determines that giveaway weakness is due to pain attributable to the compensable injury. If there is no measurable impairment, no award of permanent disability is allowed for pain. To the extent that pain results in disability greater than that evidenced by the measurable impairment, including the disability due to expected waxing and waning of the worker's compensable injury, this loss of earning capacity is considered and valued under OAR 436-035-0012 and is included in the adaptability factor.

(9) Methods used by the examiner for making findings of impairment are the methods described in these rules and further outlined in [Bulletin 239](#), and are reported by the physician in the form and format required by these rules.

(10) Range of motion is measured using the goniometer, except when measuring spinal range of motion; then an inclinometer must be used. Reproducibility of abnormal motion is used to validate optimum effort.

(a) For obtaining goniometer measurements, center the goniometer on the joint with the base in the neutral position. Have the worker actively move the joint as far as possible in each motion with the arm of the goniometer following the motion. Measure the angle that subtends the arc of motion. To determine ankylosis, measure the deviation from the neutral position.

(b) There are three acceptable methods for measuring spinal range of motion: the simultaneous application of two inclinometers, the single fluid-filled inclinometer, and an electronic device capable of calculating compound joint motion. The examiner must take at least three consecutive measurements of mobility, which must fall within 10% or 5 degrees (whichever is greater) of each other to be considered consistent. The measurements must be repeated up to six times to obtain consecutive measurements that meet these criteria. Inconsistent measurements may be considered invalid and that portion of the examination disqualified. If acute spasm is noted, the worker should be re-examined after the spasm resolves.

(11) Validity is established for findings of impairment under the criteria noted in these rules and further outlined in [Bulletin 239](#), unless the validity criteria for a particular finding is not addressed, or is determined by physician opinion to be medically inappropriate for a particular worker. Upon examination, findings of impairment that are determined to be ratable under these rules are rated unless the physician determines the findings are invalid. When findings are determined invalid, the findings receive a value of zero. If the validity criteria are not met but the physician determines the findings are valid, the physician must provide a written rationale, based on sound medical principles, explaining why the findings are valid. For purposes of this rule, the straight leg raising validity test (SLR) is not the sole criterion used to invalidate lumbar range of motion findings.

(12) Except for contralateral comparison determinations under OAR 436-035-0011(3), loss of opposition determination under OAR 436-035-0040, averaging muscle values under OAR 436-035-0011(8), and impairment determined under ORS 656.726(4)(f), only impairment values listed in these rules are to be used in determining impairment. Prorating or interpolating between the listed values is not allowed. For findings that fall between the listed impairment values, the next higher appropriate value is used for rating.

(13) Values found in these rules consider the loss of use, function, or earning capacity directly associated with the compensable injury. When a worker's impairment findings do not meet the threshold (minimum) findings established in these rules, no value is granted.

(a) Not all surgical procedures result in loss of use, function, or earning capacity. Some surgical procedures improve the use and function of body parts, areas, or systems or ultimately may contribute to an increase in earning capacity. Accordingly, not all surgical procedures receive a value under these rules.

(b) Not all medical conditions or diagnoses result in loss of use, function, or earning capacity. Accordingly, not all medical conditions or diagnoses receive a value under these rules.

(14) Waxing and waning of signs or symptoms related to a worker's compensable injury are already contemplated in the values provided in these rules. There is no additional value granted for the varying extent of waxing and waning of the compensable injury. Waxing and waning means there is not an actual worsening of the condition under ORS 656.273.

Stat. Auth.: ORS 656.726
Stats. Impltd.: ORS 656.005, 656.214, 656.245, 656.267, 656.268, 656.273, 656.726
Hist: Amended 2/7/20 as Admin. Order 20-051, eff. 3/1/20
Amended 6/7/22 as Admin. Order 22-052, eff. 6/7/22 (temp)
Amended 11/8/22 as WCD Admin. Order 22-064, eff. 12/4/22

436-035-0008 Calculating Disability Benefits (Dates of Injury prior to 1/1/2005)

(1) Scheduled disability with a date of injury prior to January 1, 2005, is rated on the permanent loss of use or function of a body part caused by a compensable injury. To calculate the scheduled impairment benefit, use the following steps:

(a) Determine the percent of scheduled impairment using the impairment values found in OAR 436-035-0019 through 436-035-0260, and the applicable procedures within these rules.

(b) Multiply the result in (a) by the maximum degrees, under ORS 656.214, for the injured body part.

(c) Multiply the result from (b) by the statutory dollar rate under ORS 656.214 and illustrated in [Bulletin 111](#).

(d) The result from (c) is the scheduled impairment benefit. If there are multiple extremities with impairment then each is determined and awarded separately, including hearing and vision loss.

Example: Scheduled impairment benefit
0.12 Scheduled impairment percent (12%)
x 192 Maximum degrees for the body part
= 23.04 Degrees of scheduled disability
x \$559.00 Statutory dollar rate per degree
= \$12,879.36 Scheduled impairment benefit

(2) Unscheduled disability with a date of injury prior to January 1, 2005, is rated on the permanent loss of use or function of a body part or system caused by a compensable injury, as modified by the factors of age, education, and adaptability.

(a) To calculate the unscheduled impairment benefit when the worker returns or is released to regular work according to OAR 436-035-0009(3), use the following steps.

(A) Determine the percent of unscheduled impairment using the impairment values found in OAR 436-035-0019 and OAR 436-035-0330 through 436-035-0450, and the applicable procedures within these rules.

(B) Multiply the result in (A) by the maximum degrees for unscheduled impairment.

(C) Multiply the result in (B) by the statutory dollar rate under ORS 656.214 and illustrated in [Bulletin 111](#).

(D) The result in (C) is the unscheduled impairment benefit.

Example: Unscheduled impairment benefit (worker returns/is released to regular work)

0.12 Unscheduled impairment percent (12%)
x 320 Maximum degrees for unscheduled impairment
= 38.40 Degrees of unscheduled disability
x \$184.00 Statutory dollar rate per degree
= \$7,065.60 Unscheduled impairment benefit

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(b) To calculate the unscheduled disability benefit when the worker does not return or is not released to regular work according to OAR 436-035-0009(3), use the following steps.

(A) Determine the percent of unscheduled impairment using the impairment values found in OAR 436-035-0019 and OAR 436-035-0330 through 436-035-0450, and the applicable procedures within these rules.

(B) Determine the social-vocational factor, under OAR 436-035-0012, and add it to (A).

(C) Multiply the result from (B) by the maximum degrees for unscheduled impairment.

(D) Multiply the result from (C) by the statutory dollar rate for unscheduled impairment under ORS 656.214.

(E) The result from (D) is the unscheduled impairment benefit.

Example:

Unscheduled impairment benefit (worker does not return/released to regular work)

0.12 Unscheduled impairment percentage (12%)

+ 6% Social-vocational factor

= 18% Unscheduled impairment

X 320 Maximum degrees for unscheduled impairment

= 57.6 Degrees of unscheduled disability

X \$184.00 Statutory dollar rate per degree

= \$10,598.40 Unscheduled impairment benefit

Stat. Auth.: ORS 656.726;

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726;

Hist.: Amended 1/29/15 as WCD Admin. Order 15-053, eff. 3/1/15

436-035-0009 Calculating Disability Benefits (Date of Injury on or after 1/1/2005)

(1) Permanent impairment is expressed as a percent of the whole person and the impairment value will not exceed 100% of the whole person.

(2) If the impairment results from injury to more than one extremity, area, or system, the whole person values for each are combined (not added) to arrive at a final impairment value.

(3) Only permanent impairment is rated for those workers with a date of injury prior to January 1, 2006, and who:

(a) Return to and are working at their regular work on the date of issuance;

(b) The attending physician or authorized nurse practitioner releases to regular work and the work is available, but the worker fails or refuses to return to that job; or

(c) The attending physician or authorized nurse practitioner releases to regular work, but the worker's employment is terminated for cause unrelated to the injury.

(4) Only permanent impairment is rated for those workers with a date of injury on or after January 1, 2006, and who have been released or returned to regular work by the attending physician or authorized nurse practitioner.

(5) To calculate the impairment benefit due to the worker, use the following steps:

(a) Determine the percent of impairment under these rules.

(b) Multiply the percent of impairment determined in (a) by 100 per ORS 656.214.

(c) Multiply the result from (b) by the state's average weekly wage at the time of injury as defined by ORS 656.005 and illustrated in [Bulletin 111](#).

(d) The result in (c) is the total impairment benefit, which is paid regardless of the worker's return to work status. In the absence of social-vocational factoring as a result of the worker's return to work status, this is also the permanent partial disability award.

Example: Impairment benefit (paid regardless of return to work status)

0.12	Impairment percent (12%)
x 100	
x \$688.56	State's average weekly wage (SAWW)
= \$8,262.72	Impairment benefit

(6) If the worker has not met the return or release to regular work criteria in section (3) or (4) of this rule, the worker receives both an impairment and work disability benefit, and the total permanent partial disability award is calculated as follows.

(a) Determine the percent of impairment as a whole person (WP) value under these rules.

(b) Determine the social-vocational factor, under OAR 436-035-0012, and add it to (a).

(c) Multiply the result from (b) by 150 per ORS 656.214.

(d) Multiply the result from (c) by worker's average weekly wage as calculated under ORS 656.210.

(A) Supplemental disability is not considered in the determination of the worker's average weekly wage when calculating work disability.

(B) The worker's average weekly wage can be no less than 50% and no more than 133% of the state's average weekly wage at the time of injury when determining work disability benefits.

(e) Add the result from (d) to the impairment benefit value, which would be calculated using the method in section (4) of this rule.

(f) The result from (e) is the permanent partial disability award that would be due the worker.

Example: Work disability benefit and PPD award (no return to work)

0.12	Impairment percentage – WP percentage (12%)
+ 0.06	Social-vocational factor (6%)
= 0.18	Work disability percentage (18%)
x 150	
x \$410.00	Worker's average weekly wage at injury
= \$11,070.00	Work disability benefit
+ \$8,262.72	Impairment benefit
= \$19,332.72	PPD award

Stat. Auth.: ORS 656.726;

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

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436-035-0011 Determining Percent of Impairment

(1) The total impairment rating for a body part cannot be more than 100% of the body part.

(2) When rating disability the movement in a joint is measured in active degrees of motion. Impairment findings describing lost ranges of motion are converted to retained ranges of motion by subtracting the measured loss from the normal of full ranges established in these rules.

(a) Range of motion values for each direction in a single joint are first added, then combined with other impairment findings.

Example: Range of motion of elbow Arm Impairment

flexion to 120°	8%
extension to 30°	6%
Add	14%
Other Impairment Values	
Weakness	7%
Prosthetic radial head replacement	10%
Combine 14 and 10 = 23	
23 and 7 = 28% total Arm Impairment	

(b) Range of motion values for multiple joints in a single body part (e.g., of a finger) are determined by finding the range of motion values for each joint (e.g., MCP, PIP, DIP) and combining those values for an overall loss of range of motion value for that body part. This value is then combined with other impairment values.

(3) The range of motion or laxity (instability) of an injured joint is compared to and valued proportionately to the contralateral joint except when the contralateral joint has a history of injury or disease or when either joint's range of motion is zero degrees or is ankylosed. The strength of an injured extremity, shoulder, or hip may be compared to and valued proportionately to the contralateral body part except when the contralateral body part has a history of injury or disease.

Instability example:

The injured knee is reported to have severe instability of the anterior cruciate ligament. The standards grant an impairment value of 15% for severe instability of the anterior cruciate ligament.

The contralateral knee is reported to have mild instability of the anterior cruciate ligament. The standards grant an impairment value of 5% for mild instability of the anterior cruciate ligament.

A proportion is established by subtracting the contralateral instability of 5% from the 15% for the injured joint which = 10% impairment for the instability.

Strength example:

The injured deltoid muscle is reported to have 3/5 strength. The standards note 3/5 strength = 50%.

The contralateral deltoid muscle is reported to have 4+/5 strength. The standards note 4+/5 strength = 10%.

A proportion is established by subtracting the contralateral strength of 10% from the 50% for the injured arm which = 40%. This percentage is then used to determine the loss of strength for the injured deltoid.

Range of motion examples:

Flexion (knee): 80° retained on injured side, the contralateral joint flexes to 140°.

A proportion is established to determine the expected degrees of flexion since 140° has been established as normal for this worker.

One method of determining this proportion is: $80/140 = X/150$.

X = expected retained range of motion compared to the established norm of 150° upon which flexion is determined under these rules. X, in this case, equals 86°.

86° of retained flexion of the knee is calculated under these rules, after rounding, to 23% impairment.

Extension (knee): 35° retained on injured side, the contralateral joint extends to 15°. First, find the complement, i.e., $150 - 15 = 135$ (uninjured) and $150 - 35 = 115$ (injured). Next, using the same method as for flexion, $115/135 = X/150$, or, $X = 127.77$. Then, revert back, so, $150 - 127.77 = 22.23$ rounded to 22° for an impairment value of 9%.

(a) If the motion of the injured or contralateral joint exceeds the values for ranges of motion established under these rules, the values established under these rules are maximums used to establish impairment.

(b) When the contralateral joint has a history of injury or disease, the findings of the injured joint are valued based upon the values established under these rules.

(4) Specific impairment findings (e.g., weakness, reduced range of motion, etc.) are awarded in whole number increments. This may require rounding non-whole number percentages and contralateral comparison degrees of motion for given impairment findings before combining with any other applicable impairment value.

(a) Except for subsection (b) of this section, before combining, the sum of the impairment values is rounded to the nearest whole number. For the decimal portion of the number, point 5 and above is rounded up, below point 5 is rounded down.

Example:

Range of motion of the wrist	Impairment
Dorsiflexion 36°	= 3.80%
Flexion 63°	= 1.40%
Radial deviation 16°	= 0.80%
Deviation 7°	= 4.30%
Add range of motion findings in a single joint. (Sum of impairment values)	10.30%
Round to nearest whole number	10%

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(b) When the sum of impairment values is greater than zero and less than 0.5, a value of 1% will be granted.

Example:

Range of motion of the wrist	Impairment
Dorsiflexion 60°	= 0.00%
Flexion 69°	= 0.20%
Radial deviation 19°	= 0.20%
Ulnar deviation 30°	= 0.00%
Add range of motion findings in a single joint.	= 0.40%
Since the value is greater than zero and less than 0.5%, the award is 1% of wrist.	= 1.00%
(sum of impairment values)	

(5) If there are impairment findings in two or more body parts in an extremity, the total impairment findings in the distal body part are converted to a value in the most proximal body part under the applicable conversion chart in these rules. This conversion is done prior to combining impairment values for the most proximal body part.

Example:

Wrist	Range of motion
	Extension: 50° = 2%
	Flexion: 40° = 5%
	Add 7%
Elbow	Range of motion
	Flexion: 110° = 10% arm
Convert (wrist) to arm per OAR 436-035-0090: 7% wrist = 6% arm	
Combine 10% with 6% = 15% arm	

(6) Except as otherwise noted in these rules, impairment values to a given body part, area, or system are combined as follows:

(a) The combined value is obtained by inserting the values for A and B into the formula $A + B(1.0 - A)$. The larger of the two numbers is A and the smaller is B. The whole number percentages of impairment are converted to their decimal equivalents (e.g., 12% converts to .12; 3% converts to .03). The resulting percentage is rounded to a whole number as determined in section (1) of this rule. Upon combining the largest two percentages, the resulting percentage is combined with any lesser percentage(s) in descending order using the same formula until all percentages have been combined prior to performing further computations. After the calculations are completed, the decimal result is then converted back to a percentage equivalent. Example: $.12 + .03(1.0 - .12) = .12 + .03(.88) = .12 + .0264 = .1464 = 14.6 = 15$.

Example:

Impairment of the wrist/hand	Impairment
Loss of range of motion	= 6% of the wrist/hand
Weakness of wrist	= 9% of the wrist/hand
Carpal bone surgery	= 5% of the wrist/hand
Combine 9 and 6 = 14; then combine 14 and 5 = 18% total impairment wrist/hand	

(b) Impairment values for a given body part, area, or system must be combined before combining with other impairment values. If the given body part is an upper or lower extremity, ear(s), or eye(s) then the impairment value is to be converted to a whole person value before combining with other impairment values, except when the date of injury for the claim is prior to Jan. 1, 2005.

Example:

Low back	Impairment
Range of motion	10%
Surgery	9%
Fractured vertebrae	7%
Combine 10 and 9 = 18;	
Then combine 18 and 7 = 24% low back (combined value)	
Arm	
Range of motion	5%
Surgery	8%
Combine 8 and 5 = 13% arm (combined value)	
Convert 13% arm to 8% whole person	
Overall impairment:	
Combined 24% (low back) with 8% (arm) = 30% impairment	

(7) Loss of strength is determined using the modified 0 to 5 international grading system described below. The grade of strength is reported by the physician and assigned a percentage value from the table in subsection (a) of this section. The impairment value of the involved nerve, which supplies (innervates) the weakened muscle, is multiplied by this value. Grades identified as "++" or "--" are considered either a "+" or "-", respectively.

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(a) The grading is valued as follows:

Grade	Description	Percent
5/5:	The worker retains range of motion against gravity with full resistance applied.	0%
5-/5		5%
4+/5		10%
4/5:	The worker retains range of motion against gravity with some resistance applied.	20%
4-/5		30%
3+/5		40%
3/5:	The worker retains range of motion against gravity without resistance applied	50%
3-/5		60%
2+/5		70%
2/5:	The worker retains range of motion with gravity eliminated.	75%
2-/5		80%
1+/5		85%
1/5:	The worker has evidence of slight muscle contractility; no joint motion.	90%
1-/5		95%
0/5:	The worker has no evidence of muscle contractility	100%

(b) When a physician reports a loss of strength with muscle action (e.g., flexion, extension, etc.) or when only the affected muscle(s) is identified, anatomy texts or the AMA Guides to the Evaluation of Permanent Impairment may be referenced to identify the specific muscle(s), peripheral nerve(s) or spinal nerve root(s) involved. A copy of the standards referenced in this rule is available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301, 503-947-7810.

(8) For muscles supplied (innervated) by the same nerve, the loss of strength is determined by averaging the percentages of impairment for each involved muscle to arrive at a single percentage of impairment for the involved nerve.

Example: Forearm

Radial nerve (50%) supplies (innervates):

Muscles	(grade)	(%)	(nerve)	
Supinator	4/5 =	20%	x .50	= 10%
Extensor carpi radialis	3/5 =	50%	x .50	= 25%
Extensor carpi ulnaris	4/5 =	20%	x .50	= 10%
Add				45%

Average $45\% \div 3 = 15\%$ impairment to radial nerve

(9) When multiple nerves have impairment findings found under these rules, these impairment values are first combined for an overall loss of strength value for the body part before combining with other impairment values.

(10) When a joint is ankylosed in more than one direction or plane, the largest ankylosis value is used for rating the loss or only one of the values is used if they are identical. This value is

granted in lieu of all other range of motion or ankylosis values for that joint.

Stat. Auth.: ORS 656.726:

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

**436-035-0012 Social-Vocational Factors
(Age/Education/Adaptability) and the Calculation of Work Disability**

(1) Social-vocational factors.

(a) If a worker is eligible for an award for work disability, the factors of age, education, and adaptability are determined under this rule and used to calculate the worker's social-vocational factor. The social-vocational factor is determined according to the steps described in section (15) of this rule and is used in the calculation of permanent disability benefits.

(b) When the date of injury is prior to Jan. 1, 2005, the worker must have ratable unscheduled impairment under OAR 436-035-0019 or OAR 436-035-0330 through 436-035-0450.

(2) The age factor is based on the worker's age at the date of issuance and has a value of 0 or +1.

(a) Workers age 40 and above receive a value of + 1.

(b) Workers less than 40 years old receive a value of 0.

(3) The education factor is based on the worker's formal education and specific vocational preparation (SVP) time at the date of issuance. These two values are determined by sections (4) and (5) of this rule, and are added to give a value from 0 to +5.

(4) A value of a worker's formal education is given as follows:

(a) Workers who have earned or acquired a high school diploma or general equivalency diploma (GED) are given a neutral value of 0. For purposes of this section, a GED is a certificate issued by any certifying authority or its equivalent.

(b) Workers who have not earned or acquired a high school diploma or a GED certificate are given a value of +1.

(5) A value for a worker's specific vocational preparation (SVP) time is given based on the jobs successfully performed by the worker in the five years prior to the date of issuance. The SVP value is determined by identifying these jobs and locating their SVP in the *Dictionary of Occupational Titles* (DOT) or a specific job analysis. The job with the highest SVP the worker has met is used to assign a value according to the following table:

SVP	Value	Training time
1	4	Short demonstration
2	4	Short demonstration up to 30 days
3	3	30+ days - 3 months
4	3	3+ months - 6 months
5	2	6+ months - 1 year
6	2	1+ year - 2 years
7	1	2+ years - 4 years
8	1	4+ years - 10 years
9	1	10+ years

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A copy of the *Dictionary of Occupational Titles* referenced in this rule is available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301, 503-947-7810.

(a) For the purposes of this rule, SVP is defined as the amount of time required by a typical worker to acquire the knowledge, skills, and abilities needed to perform a specific job.

(b) When a job is most accurately described by a combination of DOT codes, use all applicable DOT codes. If a preponderance of evidence establishes that the requirements of a specific job differ from the DOT descriptions, one of the following may be substituted for the DOT descriptions if it more accurately describes the job:

(A) A specific job analysis as described under OAR 436-120-0410, which includes the SVP time requirement; or

(B) A job description that the parties agree is an accurate representation of the physical requirements, as well as the tasks and duties, of the worker's regular job-at-injury.

(c) A worker is presumed to have met the SVP training time after completing employment with one or more employers in that job classification for the time period specified in the table.

(d) A worker meets the SVP for a job after successfully completing an authorized training program, on-the-job training, vocational training, or apprentice training for that job classification. College training organized around a specific vocational objective is considered specific vocational training.

(e) For those workers who have not met the specific vocational preparation training time for any job, a value of +4 is granted.

(6) The values obtained in sections (4) and (5) of this rule are added to arrive at a final value for the education factor.

(7) The adaptability factor is an evaluation of the extent to which the compensable injury has permanently restricted the worker's ability to perform work activities. The adaptability factor is determined by performing a comparison of the worker's base functional capacity to the worker's residual functional capacity, under sections (8) through (14) of this rule, and is given a value from +1 to +7.

(8) For purposes of determining adaptability, the following definitions apply:

(a) "**Base functional capacity**" (BFC) is established under section (9) of this rule and means an individual's demonstrated ability to perform work-related activities before the date of injury or disease.

(b) "**Residual functional capacity**" (RFC) is established under section (10) of this rule and means an individual's remaining ability to perform work-related activities at the time the worker is medically stationary.

(c) "**Sedentary restricted**" means the worker only has the ability to carry or lift dockets, ledgers, small tools, and other items weighing less than 10 pounds. A worker is also sedentary restricted if the worker can perform the full range of sedentary activities, but with restrictions.

(d) "**Sedentary (S)**" means the worker has the ability to occasionally lift or carry dockets, ledgers, small tools and other items weighing 10 pounds.

(e) "**Sedentary/light (S/L)**" means the worker has the ability to do more than sedentary activities, but less than the full range of light activities. A worker is also sedentary/light if the worker can perform the full range of light activities, but with restrictions.

(f) "**Light (L)**" means the worker has the ability to occasionally lift 20 pounds and can frequently lift or carry objects weighing up to 10 pounds.

(g) "**Medium/light (M/L)**" means the worker has the ability to do more than light activities, but less than the full range of medium activities. A worker is also medium/light if the worker can perform the full range of medium activities, but with restrictions.

(h) "**Medium (M)**" means the worker can occasionally lift 50 pounds and can lift or carry objects weighing up to 25 pounds frequently.

(i) "**Medium/heavy (M/H)**" means the worker has the ability to do more than medium activities, but less than the full range of heavy activities. A worker is also medium/heavy if the worker can perform the full range of heavy activities, but with restrictions.

(j) "**Heavy (H)**" means the worker has the ability to occasionally lift 100 pounds and the ability to frequently lift or carry objects weighing 50 pounds.

(k) "**Very Heavy (V/H)**" means the worker has the ability to occasionally lift in excess of 100 pounds and the ability to frequently lift or carry objects weighing more than 50 pounds.

(l) "**Restrictions**" means that, by a preponderance of medical opinion, the worker is permanently limited from:

(A) Sitting, standing, or walking less than two hours at a time; or

(B) Working the same number of hours as were worked at the time of injury, including any regularly worked overtime hours; or

(C) Frequently performing at least one of the following activities: stooping, bending, crouching, crawling, kneeling, twisting, climbing, balancing, reaching, pushing, or pulling; or

(D) Frequently performing at least one of the following activities involving the hand: fine manipulation, squeezing, or grasping.

(m) "**Occasionally**" means the activity or condition exists up to 1/3 of the time.

(n) "**Frequently**" means the activity or condition exists up to 2/3 of the time.

(o) "**Constantly**" means the activity or condition exists 2/3 or more of the time.

(9) **Base Functional Capacity.** Base functional capacity (BFC) is established by using the following classifications: sedentary (S), light (L), medium (M), heavy (H), and very heavy (VH) as defined in section (8) of this rule. The strength

classifications are found in the *Dictionary of Occupational Titles* (DOT). Apply the subsection in this section that most accurately describes the worker's base functional capacity.

(a) The highest strength category of the jobs successfully performed by the worker in the five years prior to the date of injury.

(A) A combination of DOT codes when they describe the worker's job more accurately.

(B) A specific job analysis, which includes the strength requirements, may be substituted for the DOT descriptions if it most accurately describes the job. If a job analysis determines that the strength requirements are in between strength categories then use the higher strength category.

(C) A job description that the parties agree is an accurate representation of the physical requirements, as well as the tasks and duties, of the worker's regular job-at-injury. If the job description determines that the strength requirements are in between strength categories then use the higher strength category.

(b) A second-level physical capacity evaluation as defined in OAR 436-010-0005 and 436-009-0060(2) performed prior to the date of the work injury.

(c) For those workers who do not meet the requirements under section (5) of this rule, and who have not had a second-level physical capacity evaluation performed prior to the work injury or disease, their prior strength is based on the worker's job at the time of injury.

(d) When a worker's highest prior strength has been reduced as a result of an injury or condition which is not an accepted Oregon workers' compensation claim the base functional capacity is the highest of:

(A) The job at injury; or

(B) A second-level physical capacities evaluation as defined in OAR 436-010-0005 and 436-009-0060(2) performed after the injury or condition which was not an accepted Oregon workers' compensation claim but before the current work related injury.

(10) Residual Functional Capacity. Residual functional capacity (RFC) is established by using the following classifications: restricted sedentary (RS), sedentary (S), sedentary/light (S/L), light (L), medium/light (M/L), medium (M), medium/heavy (M/H), heavy (H), and very heavy (VH), and restrictions as defined in section (8) of this rule.

(a) **Medical findings.** Residual functional capacity is evidenced by the attending physician's release unless a preponderance of medical opinion describes a different RFC.

(b) **Other medical opinions.** For the purposes of subsection (a) of this section, the other medical opinion must include at least a second-level physical capacity evaluation (PCE) or work capacity evaluation (WCE) as defined in OAR 436-010-0005 and 436-009-0060(2) or a medical evaluation that addresses the worker's capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, stooping, bending, kneeling, crouching, crawling, and reaching. If multiple levels of lifting and carrying are measured, an overall

analysis of the worker's lifting and carrying abilities should be provided in order to allow an accurate determination of these abilities. When the worker fails to cooperate or complete a residual functional capacity (RFC) evaluation, the evaluation must be rescheduled or the evaluator must estimate the worker's RFC as if the worker had cooperated and used maximal effort.

(c) Work capacity diminished in part by a superimposed condition, a pre-existing condition that is part of a combined condition denial, or a combined condition denied in its entirety. Residual functional capacity is a measure of the extent to which the worker's capacity to perform work is diminished by the compensable injury. If the worker's capacity to perform work is diminished in part by a superimposed condition, a pre-existing condition that is part of a combined condition denial, or a combined condition denied in its entirety, the worker's residual functional capacity must be adjusted based on an estimate of what the worker's capacity to perform work would be if it had not been diminished by the superimposed condition, the pre-existing condition that is part of a combined condition denial, or the combined condition denied in its entirety.

(d) When the worker is not medically stationary. Except for a claim closed under ORS 656.268(1)(c), if a worker is not medically stationary, residual functional capacity is determined based on an estimate of what the worker's capacity to perform work would be if measured at the time the worker is likely to become medically stationary.

(e) When the worker is not medically stationary and work capacity is diminished in part by a superimposed condition, a pre-existing condition that is part of a combined condition denial, or a combined condition denied in its entirety.

Except for a claim closed under ORS 656.268(1)(c), if a worker is not medically stationary and the worker's capacity to perform work is diminished in part by a superimposed condition, a pre-existing condition that is part of a combined condition denial, or a combined condition denied in its entirety, residual functional capacity is determined based on an estimate of what the worker's capacity to perform work would be if measured at the time the worker is likely to become medically stationary and if the worker's capacity to perform work had not been diminished by the superimposed condition, the pre-existing condition that is part of a combined condition denial, or the combined condition denied in its entirety.

(f) Lifting capacity. For the purposes of the determination of residual functional capacity, the worker's lifting capacity is based on the whole person, not an individual body part.

(g) Injuries before Jan. 1, 2005. If the date of injury is before Jan. 1, 2005, residual functional capacity is determined under this section and is further adjusted based on an estimate of what the worker's capacity to perform work would be if it had only been diminished by a compensable injury to the hip, shoulder, head, neck, or torso.

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(11) In comparing the worker's base functional capacity (BFC) to the residual functional capacity (RFC), the values for adaptability to perform a given job are as follows:

Residual functional capacity (RFC)										
Base functional capacity (BFC) (physical demand)		RS	S	S/L	L	M/L	M	M/H	H	V/H
	S	2	1	1	1	1	1	1	1	1
	L	4	3	2	1	1	1	1	1	1
	M	6	5	4	3	2	1	1	1	1
	H	7	6	6	5	4	3	2	1	1
	V/H	7	7	6	5	4	3	2	1	1

(12) For those workers who have an RFC between two categories and who also have restrictions, the next lower classification is used. (For example, if a worker's RFC is S/L and the worker has restrictions, use S).

(13) When the date of injury is on or after Jan. 1, 2005, determine adaptability by finding the adaptability value for the worker's extent of total impairment on the adaptability scale below; compare this value with the residual functional capacity scale in section (11) of this rule and use the higher of the two values for adaptability.

Adaptability Scale:

Total impairment	Adaptability value
1-9%	1
10-19%	2
20-29%	3
30-39%	4
40-49%	5
50-59%	6
60% and over	7

(14) When the date of injury is before Jan. 1, 2005, for those workers who have ratable unscheduled impairment found in rules OAR 436-035-0019 or OAR 436-035-0330 through 436-035-0450, determine adaptability by applying the extent of total unscheduled impairment to the adaptability scale in section (13) of this rule and the residual functional capacity scale in section (11) of this rule and use the higher of the two values for adaptability.

(15) To determine the social-vocational factor value, which represents the total calculation of age, education, and adaptability, complete the following steps.

- (a) Determine the appropriate value for the age factor using section (2) of this rule.
- (b) Determine the appropriate value for the education factor using sections (4) and (5) of this rule.
- (c) Add age and education values together.
- (d) Determine the appropriate value for the adaptability factor using sections (7) through (14) of this rule.
- (e) Multiply the result from step (c) by the value from step (d) for the social-vocational factor value.

(16) Prorating or interpolating between social-vocational values is not allowed. All values must be expressed as whole numbers.

Stat. Auth.: ORS 656.726

Stats. Impltd.: ORS 656.005, 656.214, 656.268, 656.726

Hist: Amended 11/8/22 as WCD Admin. Order 22-064, eff. 12/4/22

436-035-0013 Findings of Impairment

(1) **Findings of impairment, generally.** Findings of impairment are objective medical findings that measure the extent to which a worker has suffered permanent loss of use or function of a body part or system.

(2) **Findings of impairment when the worker is medically stationary.** If the worker is medically stationary, findings of impairment are determined by performing the following steps:

(a) **In initial injury claims.**

(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted condition or a direct medical sequela of an accepted condition.

(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and

(C) Establish the portion of the loss caused by:

(i) Any accepted condition;

(ii) Any direct medical sequela of an accepted condition;

(iii) Any condition that existed before the initial injury incident but does not qualify as a pre-existing condition;

(iv) Any pre-existing condition that is not otherwise compensable;

(v) Any denied condition; and

(vi) Any superimposed condition.

Example: **Accepted condition: Low back strain combined with pre-existing lumbar degenerative disc disease**

Denied condition: major contributing cause denial of the combined condition

In the closing examination, the attending physician describes range of motion findings and states that 10% of the range of motion loss is due to the accepted condition and 90% of the loss is due to lumbar degenerative disc disease. The worker is eligible for an impairment award for the 10% of the range of motion loss that is due to the low back strain. Under these rules, the range of motion loss is valued at 10%. 10% x .10 equals 1% impairment.

(b) **In new or omitted condition claims.**

(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

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(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and

(C) Establish the portion of the loss caused by:

(i) Any accepted new or omitted condition;

(ii) Any direct medical sequela of an accepted new or omitted condition;

(iii) In a new condition claim, any condition that existed before the onset of the accepted new medical condition but does not qualify as a pre-existing condition;

(iv) In an omitted condition claim, any condition that existed before the initial injury incident but does not qualify as a pre-existing condition;

(v) Any pre-existing condition that is not otherwise compensable;

(vi) Any denied condition; and

(vii) Any superimposed condition.

(c) In aggravation claims.

(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and

(C) Establish the portion of the loss caused by:

(i) Any accepted worsened condition;

(ii) Any direct medical sequela of an accepted worsened condition;

(iii) Any condition that existed before the onset of the accepted worsened condition but does not qualify as a pre-existing condition;

(iv) Any pre-existing condition that is not otherwise compensable;

(v) Any denied condition; and

(vi) Any superimposed condition.

(d) In occupational disease claims.

(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and

(C) Establish the portion of the loss caused by:

(i) Any accepted occupational disease;

(ii) Any direct medical sequela of an accepted occupational disease;

(iii) Any pre-existing condition that is not otherwise compensable;

(iv) Any denied condition; and

(v) Any superimposed condition.

(3) Findings of impairment when the worker is not medically stationary. Except for a claim closed under ORS 656.268(1)(c), if the worker is not medically stationary, findings of impairment are determined by performing the following steps:

(a) In initial injury claims.

(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted condition or a direct medical sequela of an accepted condition at the time the worker is likely to become medically stationary;

(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and

(C) Estimate the portion of the loss that is likely to be caused by:

(i) Any accepted condition;

(ii) Any direct medical sequela of an accepted condition;

(iii) Any condition that existed before the initial injury incident but does not qualify as a pre-existing condition;

(iv) Any pre-existing condition that is not otherwise compensable;

(v) Any denied condition; and

(vi) Any superimposed condition.

(b) In new or omitted condition claims.

(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition at the time the worker is likely to become medically stationary;

(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and

(C) Estimate the portion of the loss that is likely to be caused by:

(i) Any accepted new or omitted condition;

(ii) Any direct medical sequela of an accepted new or omitted condition;

(iii) In a new condition claim, any condition that existed before the onset of the accepted new medical condition but does not qualify as a pre-existing condition;

(iv) In an omitted condition claim, any condition that existed before the initial injury incident but does not qualify as a pre-existing condition;

(v) Any pre-existing condition that is not otherwise compensable;

(vi) Any denied condition; and

(vii) Any superimposed condition.

(c) In aggravation claims.

(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted worsened condition or a direct medical sequela of an accepted worsened condition at the time the worker is likely to become medically stationary;

(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and

(C) Estimate the portion of the loss that is likely to be caused by:

- (i) Any accepted worsened condition;
- (ii) Any direct medical sequela of an accepted worsened condition;
- (iii) Any condition that existed before the onset of the accepted worsened condition but does not qualify as a pre-existing condition;
- (iv) Any pre-existing condition that is not otherwise compensable;
- (v) Any denied condition; and
- (vi) Any superimposed condition.

(d) In occupational disease claims.

(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted occupational disease or a direct medical sequela of an accepted occupational disease at the time the worker is likely to become medically stationary;

(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and

(C) Estimate the portion of the loss that is likely to be caused by:

- (i) Any accepted occupational disease;
- (ii) Any direct medical sequela of an accepted occupational disease;
- (iii) Any pre-existing condition that is not otherwise compensable;
- (iv) Any denied condition; and
- (v) Any superimposed condition.

(4) Age and education. The social-vocational factors of age and education (including SVP) are not apportioned, but are determined as of the date of issuance.

(5) Irreversible findings of impairment or surgical value. Workers with an irreversible finding of impairment or surgical value due to the compensable injury receive the full value awarded in these rules for the irreversible finding or surgical value, except in cases where the irreversible finding or surgical value is caused in part by a superimposed condition, a pre-

existing condition that is part of a combined condition denial, or a combined condition denied in its entirety. A worker is not eligible for an award for the portion of loss for an irreversible finding or surgical value caused in part by a superimposed condition, a pre-existing condition that is part of a combined condition denial, or a combined condition denied in its entirety.

Example: **Accepted conditions: Low back strain with herniated disk at L5-S1 and disectomy.**

Noncompensable condition: pregnancy (mid-term)

The worker is released to regular work. In the closing examination, the attending physician describes range of motion findings and states that 60% of the range of motion loss is due to the accepted conditions and 40% of the range of motion loss is due to the pregnancy. Under these rules, the range of motion loss is valued at 10%. $10\% \times .60$ equals 6%.

Disectomy at L5-S1 (irreversible finding) = 9% per these rules.

Combine 9% with 6% for a value of 14% impairment for the compensable injury.

Statutory authority: ORS 656.726
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/8/22 as WCD Admin. Order 22-064, eff. 12/4/22

436-035-0014 Worsened Pre-existing Conditions

If a worsened pre-existing condition is compensable under ORS 656.225, a worker is eligible for an award for permanent disability caused by the worsened pre-existing condition.

Example: **(No apportionment)**

Compensable injury (remains major contributing cause): Herniated disk L5-S1/disectomy.

Pre-existing condition: arthritis (spine).

Closing exam ROM = 10% (under these rules).

Surgery (lumbar disectomy) = 9%.

Combine: 10% and 9% which equals 18% low back impairment due to this compensable injury.

The worker is released to regular work. (Social-vocational factoring equals zero.)

Stat. Auth.: ORS 656.726
Stats. Impltd.: ORS 656.005, 656.214, 656.225, 656.268, 656.726
Hist.: Amended 11/8/22 as WCD Admin. Order 22-064, eff. 12/4/22

436-035-0015 Offsetting Prior Awards

If a worker has a prior award of permanent disability under Oregon Workers' Compensation Law, the award is considered in subsequent claims under ORS 656.222 and ORS 656.214.

(1) A prior award can be used to offset an award for a subsequent claim when all the following are true:

(a) The prior claim is closed under Oregon Workers' Compensation Law;

(b) The prior claim has an award of permanent disability;

(c) The disability in the prior claim has not fully dissipated as outlined in section (2) of this rule; and

(d) Both claims have similar disabilities as outlined in sections (3) and (4) of this rule.

(2) A disability from a prior claim is considered to have fully dissipated if there is not a preponderance of medical evidence or opinion establishing that disability from the prior injury or disease was still present on the date of the injury or disease of the claim being determined. If disability from the prior injury or disease was not still present, an offset is not applied.

(3) The following are considered when determining what impairment findings can be offset from a prior claim:

(a) Only identical impairment findings of like body parts or systems are to be offset (e.g., left leg sensation loss to left leg sensation loss, chronic low back to chronic low back, psychological to psychological, etc.).

(b) A more distal body part impairment finding may be offset against a more proximal body part impairment finding (or vice versa) if there is a combined effect of impairment (e.g., a right forearm impairment finding may be offset against a right arm impairment finding).

(c) Irreversible findings and surgical values are not offset.

(4) The following are considered when determining what disability findings can be offset from a prior claim:

(a) When a worker successfully returns to work in a position requiring greater physical capacity than the RFC established at the time of claim closure in a prior claim, an offset is not applied. The BFC for the current claim closure is established under OAR 436-035-0012, without offsetting the RFC from the prior claim.

(b) The social-vocational factors of age and education (including SVP) are not offset, but are redetermined as of the date of issuance.

(5) The following are considered when calculating the current disability award and applying an offset:

(a) The worker's loss of use or function or loss of earning capacity for the current disability under the standards;

(b) The conditions or findings of impairment from the prior awards which were still present just prior to the current claim;

(c) The worker's adaptability factors which were still present just prior to the current claim, if appropriate; and

(d) The combined effect of the prior and current injuries (the overall disability to a given body part), including the extent to which the current loss of use or function or loss of earning capacity (impairment and social-vocational factors) from a prior injury or disease was still present at the time of the current injury or disease. After considering and comparing the claims, any award of compensation in the current claim for loss of use

or function or loss of earning capacity caused by the current injury or disease (which did not exist at the time of the current injury or disease and for which the worker was not previously compensated) is granted.

(e) When there is measurable impairment in the current claim and the worker has not returned to regular work but the offset applied reduces the impairment award to zero, the worker is entitled to a work disability award. The work disability calculation must include the percentage of measurable impairment from the current claim.

Stat. Auth.: ORS 656.726;

Stats. Implemented: ORS 656.005, 656.214, 656.222, 656.268, 656.726

Hist.: Amended 5/5/10 as WCD Admin. Order 10-051, eff. 6/1/10

436-035-0016 Reopened Claim for Aggravation/Worsening

(1) **Worsened conditions.** When an aggravation claim is closed, the extent of permanent disability caused by any worsened condition accepted under the aggravation claim is compared to the extent of disability that existed at the time of the last award or arrangement of compensation.

(2) **Conditions not actually worsened.** Permanent disability caused by conditions not actually worsened continues to be the same as that established at the last arrangement of compensation.

(3) **Redetermination of permanent disability.** Except as provided by ORS 656.325 and 656.268(10), where a redetermination of permanent disability under ORS 656.273 results in an award that is less than the total of the worker's prior arrangements of compensation in the claim, the award is not reduced.

Stat. Auth.: ORS 656.726, 656.273;

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 1/29/15 as WCD Admin. Order 15-053, eff. 3/1/15

436-035-0017 Authorized Training Program (ATP)

(1) When a worker ceases to be enrolled and actively engaged in training under ORS 656.268(10) and there is no accepted aggravation in the current open period, one of the following applies:

(a) When the date of injury is prior to January 1, 2005, the worker is entitled to have the amount of unscheduled permanent disability for a compensable condition re-evaluated under these rules. The re-evaluation includes impairment, which may increase, decrease, or affirm the worker's permanent disability award; or

(b) When the date of injury is on or after January 1, 2005, the worker's work disability is re-evaluated under these rules. Impairment is not re-evaluated. The re-evaluation of the work disability may increase, decrease, or affirm the worker's permanent disability award.

(2) When a worker ceases to be enrolled and actively engaged in training under ORS 656.268(10) and there is an accepted aggravation in the same open period, permanent partial disability is redetermined under OAR 436-035-0016.

Stat. Auth.: ORS 656.726;

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0018 Death

(1) **If a closing report has been completed.** If the worker dies due to causes unrelated to the compensable injury and a closing report has been completed, the worker's permanent disability must be determined based on the closing report.

(2) **If a closing report has not been completed.** If the worker dies due to causes unrelated to the compensable injury and a closing report has not been completed, findings of impairment and permanent work restrictions must be estimated.

(a) The estimate must qualify as either a statement of no permanent disability under OAR 436-030-0020(2)(a) or a closing report under OAR 436-030-0020(2)(b).

(b) If the worker was medically stationary at the time of death, the following applies:

(A) Findings of impairment and permanent work restrictions are determined based on an estimate of the permanent disability that existed at the time the worker was medically stationary; and

(B) The worker's residual functional capacity is determined based on an estimate of the worker's ability to perform work-related activities at the time the worker was medically stationary.

(c) If the worker was not medically stationary at the time of death, the following applies:

(A) Findings of impairment and permanent work restrictions are determined based on an estimate of the permanent disability that would have existed at the time the worker would have likely become medically stationary; and

(B) The worker's residual functional capacity is determined based on an estimate of the worker's ability to perform work-related activities at the time the worker would have likely become medically stationary.

(3) In claims where, at the time of death, there is a compensable condition that is medically stationary and a compensable condition that is not medically stationary, the conditions are rated under sections (1) and (2) of this rule, respectively. The adaptability factor is determined by comparing the adaptability values from sections (1) and (2) of this rule, and using the higher of the values for adaptability.

(4) If the worker dies due to causes related to the compensable injury, death benefits are due under ORS 656.204 and 656.208.

Stat. Auth.: ORS 656.726;
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 1/29/15 as WCD Admin. Order 15-053, eff. 3/1/15

436-035-0019 Chronic Condition

(1) For the purpose of this rule, "significantly limited in the repetitive use" means the worker is unable to repetitively use a body part identified in subsections (a) through (j) of this section for more than two-thirds of a period of time. A worker is entitled to a 5% chronic condition impairment value for each applicable body part, when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of one or more of the following body parts:

- (a) Lower leg (below knee/foot/ankle);
- (b) Upper leg (knee and above);
- (c) Forearm (below elbow/hand/wrist);
- (d) Arm (elbow and above);
- (e) Cervical;
- (f) Thoracic spine;
- (g) Shoulder;
- (h) Low back;
- (i) Hip; or
- (j) Chest.

(2) Chronic condition impairments are to be combined with other impairment values, not added.

Stat. Auth.: ORS 656.726
Stats. Impltd.: ORS 656.005, 656.214, 656.268, 656.726
Hist: Amended 2/7/20 as Admin. Order 20-051, eff. 3/1/20

436-035-0020 Parts of the Upper Extremities

(1) The arm begins with the head of the humerus. It includes the elbow joint.

(2) The forearm begins distal to the elbow joint and includes the wrist (carpal bones).

(3) The hand begins at the joints between the carpals and metacarpals. It extends to the joints between the metacarpals and the phalanges.

(4) The thumb and fingers begin at the joints between the metacarpal bones and the phalanges. They extend to the tips of the thumb and fingers, respectively.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 10/26/04 as WCD Admin. Order 04-063, eff. 1/1/05

436-035-0030 Amputations in the Upper Extremities

(1) Loss of the arm at or proximal to the elbow joint is 100% loss of the arm.

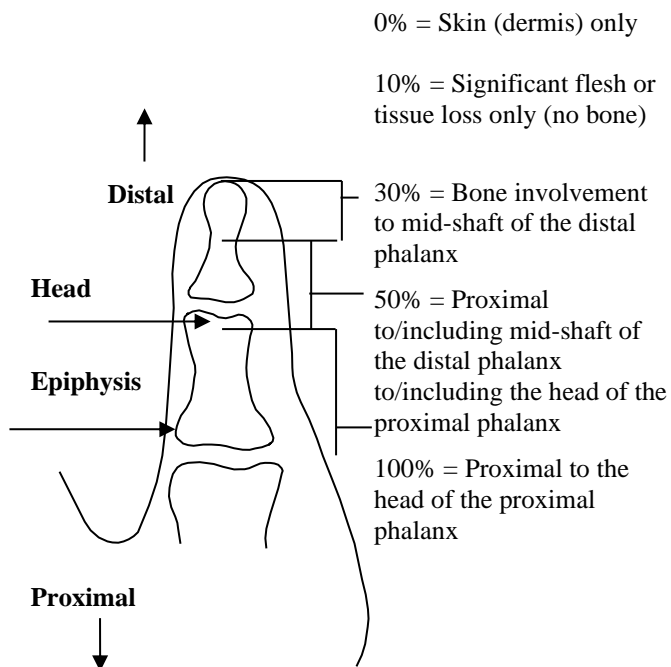
(2) Loss of the forearm at or proximal to the wrist joint is 100% loss of the forearm.

(3) Loss of the hand at the carpal bones is 100% loss of the hand.

(4) Loss of all or part of a metacarpal is rated at 10% of the hand.

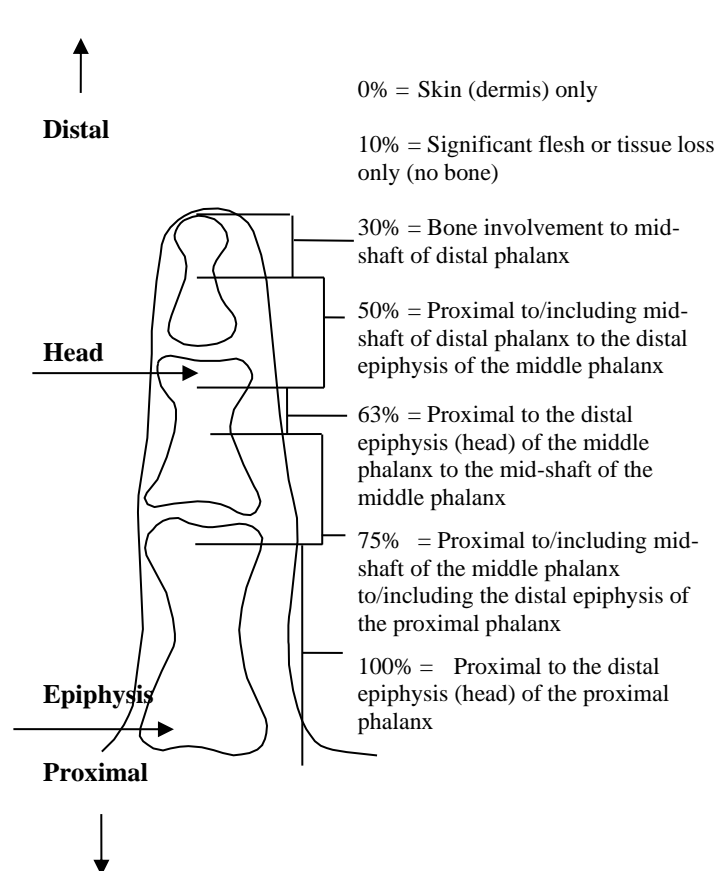
(5) Amputation or resection (without reattachment) proximal to the head of the proximal phalanx is 100% loss of the thumb. The ratings for other amputation(s) or resection(s) (without reattachment) of the thumb are as follows:

Thumb



(6) Amputation or resection (without reattachment) proximal to the head of the proximal phalanx is 100% loss of the finger. The ratings for other amputation(s) or resection(s) (without reattachment) of the finger are as follows:

Finger



(7) Oblique (angled) amputations are rated at the most proximal loss of bone.

(8) When a value is granted under sections (5) and (6) of this rule which includes a joint, no value for range of motion of this joint is granted in addition to the amputation value.

(9) Loss of length in a digit other than amputation or resection without reattachment (e.g., fractures, loss of soft tissue from infection, amputation or resection with reattachment, etc.) is rated by comparing the remaining overall length of the digit to the applicable amputation chart under these rules and rating the overall length equivalency.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

**OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
DISABILITY RATING STANDARDS**

**Administrative
Order No.
22-064**

436-035-0040 Loss of Opposition in Thumb/Finger Amputations

(1) Loss of opposition is rated as a proportionate loss of use of the digits which can no longer be effectively opposed.

(a) For amputations which are not exactly at the joints, adjust the ratings in steps of 5%, increasing as the amputation gets closer to the attachment to the hand, decreasing to zero as it gets closer to the tip.

(b) When the value for loss of opposition is less than 5%, no value is granted.

(2) The following ratings apply to thumb amputations for loss of opposition:

(a) For thumb amputations at the interphalangeal level:

Opposing digit	Finger
index finger	20%
middle finger	20%
ring finger	10%
little finger	5%

(b) For thumb amputations at the metacarpophalangeal level:

Opposing digit	Finger
index finger	40%
middle finger	40%
ring finger	20%
little finger	10%

(3) The following ratings apply to finger amputations for loss of opposition. In every case, the opposing digit is the thumb:

For finger amputations at the distal interphalangeal joint:

	Thumb
index finger	10%
middle finger	10%
ring finger	5%
little finger	5%

For finger amputations at the proximal interphalangeal joint:

	Thumb
index finger	25%
middle finger	25%
ring finger	10%
little finger	10%

For finger amputations at the metacarpophalangeal joint:

	Thumb
index finger	30%
middle finger	30%
ring finger	20%
little finger	20%

(4) When determining loss of opposition due to loss of length in a digit, other than amputation or resection without reattachment, the value is established by comparing the remaining overall length of the digit to the applicable amputation chart under these rules and rated based on the overall length equivalency.

(5) If the injury is to one digit only and opposition loss is awarded for a second digit, do not convert the two digits to loss in the hand. Conversion to hand can take place only when more than one digit has impairment without considering opposition.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0050 Thumb

(1) The following ratings are for loss of flexion at the interphalangeal joint of the thumb:

Retained Motion/Percentage of Impairment

0° = 45.0%	27° = 29.8%	54° = 14.6%
1° = 44.4%	28° = 29.2%	55° = 14.0%
2° = 43.8%	29° = 28.6%	56° = 13.4%
3° = 43.2%	30° = 28.0%	57° = 12.8%
4° = 42.6%	31° = 27.5%	58° = 12.2%
5° = 42.0%	32° = 27.0%	59° = 11.6%
6° = 41.4%	33° = 26.5%	60° = 11.0%
7° = 40.8%	34° = 26.0%	61° = 10.5%
8° = 40.2%	35° = 25.5%	62° = 10.0%
9° = 39.6%	36° = 25.0%	63° = 9.5%
10° = 39.0%	37° = 24.5%	64° = 9.0%
11° = 38.5%	38° = 24.0%	65° = 8.5%
12° = 38.0%	39° = 23.5%	66° = 8.0%
13° = 37.5%	40° = 23.0%	67° = 7.5%
14° = 37.0%	41° = 22.4%	68° = 7.0%
15° = 36.5%	42° = 21.8%	69° = 6.5%
16° = 36.0%	43° = 21.2%	70° = 6.0%
17° = 35.5%	44° = 20.6%	71° = 5.4%
18° = 35.0%	45° = 20.0%	72° = 4.8%
19° = 34.5%	46° = 19.4%	73° = 4.2%
20° = 34.0%	47° = 18.8%	74° = 3.6%
21° = 33.4%	48° = 18.2%	75° = 3.0%
22° = 32.8%	49° = 17.6%	76° = 2.4%
23° = 32.2%	50° = 17.0%	77° = 1.8%
24° = 31.6%	51° = 16.4%	78° = 1.2%
25° = 31.0%	52° = 15.8%	79° = 0.6%
26° = 30.4%	53° = 15.2%	80° = 0.0%

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22-064**

(2) The following ratings are for loss of extension at the interphalangeal joint of the thumb:

Retained Motion/Percentage of Impairment

0° = 0.0%	27° = 8.8%	54° = 24.2%
1° = 0.4%	28° = 9.2%	55° = 25.0%
2° = 0.8%	29° = 9.6%	56° = 25.8%
3° = 1.2%	30° = 10.0%	57° = 26.6%
4° = 1.6%	31° = 10.2%	58° = 27.4%
5° = 2.0%	32° = 10.4%	59° = 28.2%
6° = 2.4%	33° = 10.6%	60° = 29.0%
7° = 2.8%	34° = 10.8%	61° = 29.8%
8° = 3.2%	35° = 11.0%	62° = 30.6%
9° = 3.6%	36° = 11.2%	63° = 31.4%
10° = 4.0%	37° = 11.4%	64° = 32.2%
11° = 4.2%	38° = 11.6%	65° = 33.0%
12° = 4.4%	39° = 11.8%	66° = 33.8%
13° = 4.6%	40° = 12.0%	67° = 34.6%
14° = 4.8%	41° = 12.9%	68° = 35.4%
15° = 5.0%	42° = 13.8%	69° = 36.2%
16° = 5.2%	43° = 14.7%	70° = 37.0%
17° = 5.4%	44° = 15.6%	71° = 37.8%
18° = 5.6%	45° = 16.5%	72° = 38.6%
19° = 5.8%	46° = 17.4%	73° = 39.4%
20° = 6.0%	47° = 18.3%	74° = 40.2%
21° = 6.4%	48° = 19.2%	75° = 41.0%
22° = 6.8%	49° = 20.1%	76° = 41.8%
23° = 7.2%	50° = 21.0%	77° = 42.6%
24° = 7.6%	51° = 21.8%	78° = 43.4%
25° = 8.0%	52° = 22.6%	79° = 44.2%
26° = 8.4%	53° = 23.4%	80° = 45.0%

(3) The following ratings are for ankylosis of the interphalangeal joint of the thumb:

Joint Ankylosed at/Percentage of Impairment

0° = 45.0%	27° = 38.6%	54° = 38.8%
1° = 44.8%	28° = 38.4%	55° = 39.0%
2° = 44.6%	29° = 38.2%	56° = 39.2%
3° = 44.4%	30° = 38.0%	57° = 39.4%
4° = 44.2%	31° = 37.7%	58° = 39.6%
5° = 44.0%	32° = 37.4%	59° = 39.8%
6° = 43.8%	33° = 37.1%	60° = 40.0%
7° = 43.6%	34° = 36.8%	61° = 40.3%
8° = 43.4%	35° = 36.5%	62° = 40.6%
9° = 43.2%	36° = 36.2%	63° = 40.9%
10° = 43.0%	37° = 35.9%	64° = 41.2%
11° = 42.7%	38° = 35.6%	65° = 41.5%
12° = 42.4%	39° = 35.3%	66° = 41.8%
13° = 42.1%	40° = 35.0%	67° = 42.1%
14° = 41.8%	41° = 35.3%	68° = 42.4%
15° = 41.5%	42° = 35.6%	69° = 42.7%
16° = 41.2%	43° = 35.9%	70° = 43.0%
17° = 40.9%	44° = 36.2%	71° = 43.2%
18° = 40.6%	45° = 36.5%	72° = 43.4%

19° = 40.3%	46° = 36.8%	73° = 43.6%
20° = 40.0%	47° = 37.1%	74° = 43.8%
21° = 39.8%	48° = 37.4%	75° = 44.0%
22° = 39.6%	49° = 37.7%	76° = 44.2%
23° = 39.4%	50° = 38.0%	77° = 44.4%
24° = 39.2%	51° = 38.2%	78° = 44.6%
25° = 39.0%	52° = 38.4%	79° = 44.8%
26° = 38.8%	53° = 38.6%	80° = 45.0%

(4) The following ratings are for loss of flexion at the metacarpophalangeal joint of the thumb:

Retained Motion/Percentage of Impairment

0° = 55.0%	21° = 36.0%	41° = 17.1%
1° = 54.1%	22° = 35.0%	42° = 16.2%
2° = 53.2%	23° = 34.0%	43° = 15.3%
3° = 52.3%	24° = 33.0%	44° = 14.4%
4° = 51.4%	25° = 32.0%	45° = 13.5%
5° = 50.5%	26° = 31.0%	46° = 12.6%
6° = 49.6%	27° = 30.0%	47° = 11.7%
7° = 48.7%	28° = 29.0%	48° = 10.8%
8° = 47.8%	29° = 28.0%	49° = 9.9%
9° = 46.9%	30° = 27.0%	50° = 9.0%
10° = 46.0%	31° = 26.1%	51° = 8.1%
11° = 45.1%	32° = 25.2%	52° = 7.2%
12° = 44.2%	33° = 24.3%	53° = 6.3%
13° = 43.3%	34° = 23.4%	54° = 5.4%
14° = 42.4%	35° = 22.5%	55° = 4.5%
15° = 41.5%	36° = 21.6%	56° = 3.6%
16° = 40.6%	37° = 20.7%	57° = 2.7%
17° = 39.7%	38° = 19.8%	58° = 1.8%
18° = 38.8%	39° = 18.9%	59° = 0.9%
19° = 37.9%	40° = 18.0%	60° = 0.0%
20° = 37.0%		

**OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
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**Administrative
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(5) The following ratings are for loss of extension at the metacarpophalangeal joint of the thumb:

Retained Motion/Percentage of Impairment

0° = 0.0%	21° = 7.9%	41° = 44.8%
1° = 0.3%	22° = 9.8%	42° = 46.6%
2° = 0.6%	23° = 11.7%	43° = 48.4%
3° = 0.9%	24° = 13.6%	44° = 50.2%
4° = 1.2%	25° = 15.5%	45° = 52.0%
5° = 1.5%	26° = 17.4%	46° = 53.8%
6° = 1.8%	27° = 19.3%	47° = 55.6%
7° = 2.1%	28° = 21.2%	48° = 57.4%
8° = 2.4%	29° = 23.1%	49° = 59.2%
9° = 2.7%	30° = 25.0%	50° = 61.0%
10° = 3.0%	31° = 26.8%	51° = 62.9%
11° = 3.3%	32° = 28.6%	52° = 64.8%
12° = 3.6%	33° = 30.4%	53° = 66.7%
13° = 3.9%	34° = 32.2%	54° = 68.6%
14° = 4.2%	35° = 34.0%	55° = 70.5%
15° = 4.5%	36° = 35.8%	56° = 72.4%
16° = 4.8%	37° = 37.6%	57° = 74.3%
17° = 5.1%	38° = 39.4%	58° = 76.2%
18° = 5.4%	39° = 41.2%	59° = 78.1%
19° = 5.7%	40° = 43.0%	60° = 80.0%
20° = 6.0%		

(6) The following ratings are for ankylosis of the metacarpophalangeal joint of the thumb:

Joint Ankylosed at/Percentage of Impairment

0° = 55.0%	21° = 43.9%	41° = 61.9%
1° = 54.4%	22° = 44.8%	42° = 62.8%
2° = 53.8%	23° = 45.7%	43° = 63.7%
3° = 53.2%	24° = 46.6%	44° = 64.6%
4° = 52.6%	25° = 47.5%	45° = 65.5%
5° = 52.0%	26° = 48.4%	46° = 66.4%
6° = 51.4%	27° = 49.3%	47° = 67.3%
7° = 50.8%	28° = 50.2%	48° = 68.2%
8° = 50.2%	29° = 51.1%	49° = 69.1%
9° = 49.6%	30° = 52.0%	50° = 70.0%
10° = 49.0%	31° = 52.9%	51° = 71.0%
11° = 48.4%	32° = 53.8%	52° = 72.0%
12° = 47.8%	33° = 54.7%	53° = 73.0%
13° = 47.2%	34° = 55.6%	54° = 74.0%
14° = 46.6%	35° = 56.5%	55° = 75.0%
15° = 46.0%	36° = 57.4%	56° = 76.0%
16° = 45.4%	37° = 58.3%	57° = 77.0%
17° = 44.8%	38° = 59.2%	58° = 78.0%
18° = 44.2%	39° = 60.1%	59° = 79.0%
19° = 43.6%	40° = 61.0%	60° = 80.0%
20° = 43.0%		

(7) For losses in the carpometacarpal joint refer to OAR 436-035-0075.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 5/5/10 as WCD Admin. Order 10-051, eff. 6/1/10

436-035-0060 Finger

(1) The following ratings are for loss of flexion at the distal interphalangeal joint of any finger:

Retained Motion/Percentage of Impairment

0° = 45.0%	23° = 30.2%	47° = 14.8%
1° = 44.3%	24° = 29.6%	48° = 14.2%
2° = 43.6%	25° = 29.0%	49° = 13.6%
3° = 42.9%	26° = 28.4%	50° = 13.0%
4° = 42.2%	27° = 27.8%	51° = 12.3%
5° = 41.5%	28° = 27.2%	52° = 11.6%
6° = 40.8%	29° = 26.6%	53° = 10.9%
7° = 40.1%	30° = 26.0%	54° = 10.2%
8° = 39.4%	31° = 25.3%	55° = 9.5%
9° = 38.7%	32° = 24.6%	56° = 8.8%
10° = 38.0%	33° = 23.9%	57° = 8.1%
11° = 37.4%	34° = 23.2%	58° = 7.4%
12° = 36.8%	35° = 22.5%	59° = 6.7%
13° = 36.2%	36° = 21.8%	60° = 6.0%
14° = 35.6%	37° = 21.1%	61° = 5.4%
15° = 35.0%	38° = 20.4%	62° = 4.8%
16° = 34.4%	39° = 19.7%	63° = 4.2%
17° = 33.8%	40° = 19.0%	64° = 3.6%
18° = 33.2%	41° = 18.4%	65° = 3.0%
19° = 32.6%	42° = 17.8%	66° = 2.4%
20° = 32.0%	43° = 17.2%	67° = 1.8%
21° = 31.4%	44° = 16.6%	68° = 1.2%
22° = 30.8%	45° = 16.0%	69° = 0.6%
	46° = 15.4%	70° = 0.0%

(2) The following ratings are for loss of extension at the distal interphalangeal joint of any finger:

Retained Motion/Percentage of Impairment

0° = 0.0%	23° = 6.6%	47° = 18.7%
1° = 0.3%	24° = 6.8%	48° = 19.8%
2° = 0.6%	25° = 7.0%	49° = 20.9%
3° = 0.9%	26° = 7.2%	50° = 22.0%
4° = 1.2%	27° = 7.4%	51° = 23.2%
5° = 1.5%	28° = 7.6%	52° = 24.4%
6° = 1.8%	29° = 7.8%	53° = 25.6%
7° = 2.1%	30° = 8.0%	54° = 26.8%
8° = 2.4%	31° = 8.3%	55° = 28.0%
9° = 2.7%	32° = 8.6%	56° = 29.2%
10° = 3.0%	33° = 8.9%	57° = 30.4%
11° = 3.3%	34° = 9.2%	58° = 31.6%
12° = 3.6%	35° = 9.5%	59° = 32.8%
13° = 3.9%	36° = 9.8%	60° = 34.0%
14° = 4.2%	37° = 10.1%	61° = 35.1%
15° = 4.5%	38° = 10.4%	62° = 36.2%
16° = 4.8%	39° = 10.7%	63° = 37.3%

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17° = 5.1%	40° = 11.0%	64° = 38.4%
18° = 5.4%	41° = 12.1%	65° = 39.5%
19° = 5.7%	42° = 13.2%	66° = 40.6%
20° = 6.0%	43° = 14.3%	67° = 41.7%
21° = 6.2%	44° = 15.4%	68° = 42.8%
22° = 6.4%	45° = 16.5%	69° = 43.9%
	46° = 17.6%	70° = 45.0%

(3) The following ratings are for ankylosis in the distal interphalangeal joint of any finger:

Joint Ankylosed at/Percentage of Impairment

0° = 45.0%	23° = 36.8%	47° = 33.5%
1° = 44.6%	24° = 36.4%	48° = 34.0%
2° = 44.2%	25° = 36.0%	49° = 34.5%
3° = 43.8%	26° = 35.6%	50° = 35.0%
4° = 43.4%	27° = 35.2%	51° = 35.5%
5° = 43.0%	28° = 34.8%	52° = 36.0%
6° = 42.6%	29° = 34.4%	53° = 36.5%
7° = 42.2%	30° = 34.0%	54° = 37.0%
8° = 41.8%	31° = 33.6%	55° = 37.5%
9° = 41.4%	32° = 33.2%	56° = 38.0%
10° = 41.0%	33° = 32.8%	57° = 38.5%
11° = 40.7%	34° = 32.4%	58° = 39.0%
12° = 40.4%	35° = 32.0%	59° = 39.5%
13° = 40.1%	36° = 31.6%	60° = 40.0%
14° = 39.8%	37° = 31.2%	61° = 40.5%
15° = 39.5%	38° = 30.8%	62° = 41.0%
16° = 39.2%	39° = 30.4%	63° = 41.5%
17° = 38.9%	40° = 30.0%	64° = 42.0%
18° = 38.6%	41° = 30.5%	65° = 42.5%
19° = 38.3%	42° = 31.0%	66° = 43.0%
20° = 38.0%	43° = 31.5%	67° = 43.5%
21° = 37.6%	44° = 32.0%	68° = 44.0%
22° = 37.2%	45° = 32.5%	69° = 44.5%
	46° = 33.0%	70° = 45.0%

(4) The following ratings are for loss of flexion at the proximal interphalangeal joint of any finger:

Retained Motion/Percentage of Impairment

0° = 60.0%	34° = 39.6%	68° = 19.2%
1° = 59.4%	35° = 39.0%	69° = 18.6%
2° = 58.8%	36° = 38.4%	70° = 18.0%
3° = 58.2%	37° = 37.8%	71° = 17.4%
4° = 57.6%	38° = 37.2%	72° = 16.8%
5° = 57.0%	39° = 36.6%	73° = 16.2%
6° = 56.4%	40° = 36.0%	74° = 15.6%
7° = 55.8%	41° = 35.4%	75° = 15.0%
8° = 55.2%	42° = 34.8%	76° = 14.4%
9° = 54.6%	43° = 34.2%	77° = 13.8%
10° = 54.0%	44° = 33.6%	78° = 13.2%
11° = 53.4%	45° = 33.0%	79° = 12.6%
12° = 52.8%	46° = 32.4%	80° = 12.0%
13° = 52.2%	47° = 31.8%	81° = 11.4%
14° = 51.6%	48° = 31.2%	82° = 10.8%
15° = 51.0%	49° = 30.6%	83° = 10.2%

16° = 50.4%	50° = 30.0%	84° = 9.6%
17° = 49.8%	51° = 29.4%	85° = 9.0%
18° = 49.2%	52° = 28.8%	86° = 8.4%
19° = 48.6%	53° = 28.2%	87° = 7.8%
20° = 48.0%	54° = 27.6%	88° = 7.2%
21° = 47.4%	55° = 27.0%	89° = 6.6%
22° = 46.8%	56° = 26.4%	90° = 6.0%
23° = 46.2%	57° = 25.8%	91° = 5.4%
24° = 45.6%	58° = 25.2%	92° = 4.8%
25° = 45.0%	59° = 24.6%	93° = 4.2%
26° = 44.4%	60° = 24.0%	94° = 3.6%
27° = 43.8%	61° = 23.4%	95° = 3.0%
28° = 43.2%	62° = 22.8%	96° = 2.4%
29° = 42.6%	63° = 22.2%	97° = 1.8%
30° = 42.0%	64° = 21.6%	98° = 1.2%
31° = 41.4%	65° = 21.0%	99° = 0.6%
32° = 40.8%	66° = 20.4%	100° = 0.0%
33° = 40.2%	67° = 19.8%	

(5) The following ratings are for loss of extension at the proximal interphalangeal joint of any finger:

Retained Motion/Percentage of Impairment

0° = 0.0%	34° = 12.2%	68° = 40.2%
1° = 0.3%	35° = 12.5%	69° = 41.1%
2° = 0.6%	36° = 12.8%	70° = 42.0%
3° = 0.9%	37° = 13.1%	71° = 42.9%
4° = 1.2%	38° = 13.4%	72° = 43.8%
5° = 1.5%	39° = 13.7%	73° = 44.7%
6° = 1.8%	40° = 14.0%	74° = 45.6%
7° = 2.1%	41° = 14.9%	75° = 46.5%
8° = 2.4%	42° = 15.8%	76° = 47.4%
9° = 2.7%	43° = 16.7%	77° = 48.3%
10° = 3.0%	44° = 17.6%	78° = 49.2%
11° = 3.4%	45° = 18.5%	79° = 50.1%
12° = 3.8%	46° = 19.4%	80° = 51.0%
13° = 4.2%	47° = 20.3%	81° = 52.0%
14° = 4.6%	48° = 21.2%	82° = 53.0%
15° = 5.0%	49° = 22.1%	83° = 54.0%
16° = 5.4%	50° = 23.0%	84° = 55.0%
17° = 5.8%	51° = 24.0%	85° = 56.0%
18° = 6.2%	52° = 25.0%	86° = 57.0%
19° = 6.6%	53° = 26.0%	87° = 58.0%
20° = 7.0%	54° = 27.0%	88° = 59.0%
21° = 7.4%	55° = 28.0%	89° = 60.0%
22° = 7.8%	56° = 29.0%	90° = 61.0%
23° = 8.2%	57° = 30.0%	91° = 61.9%
24° = 8.6%	58° = 31.0%	92° = 62.8%
25° = 9.0%	59° = 32.0%	93° = 63.7%
26° = 9.4%	60° = 33.0%	94° = 64.6%
27° = 9.8%	61° = 33.9%	95° = 65.5%
28° = 10.2%	62° = 34.8%	96° = 66.4%
29° = 10.6%	63° = 35.7%	97° = 67.3%
30° = 11.0%	64° = 36.6%	98° = 68.2%
31° = 11.3%	65° = 37.5%	99° = 69.1%

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32° = 11.6%	66° = 38.4%	100° = 70.0%
33° = 11.9%	67° = 39.3%	

(6) The following ratings are for ankylosis in the proximal interphalangeal joint of any finger:

Joint Ankylosed at/Percentage of Impairment

0° = 60.0%	34° = 51.8%	68° = 59.4%
1° = 59.7%	35° = 51.5%	69° = 59.7%
2° = 59.4%	36° = 51.2%	70° = 60.0%
3° = 59.1%	37° = 50.9%	71° = 60.3%
4° = 58.8%	38° = 50.6%	72° = 60.6%
5° = 58.5%	39° = 50.3%	73° = 60.9%
6° = 58.2%	40° = 50.0%	74° = 61.2%
7° = 57.9%	41° = 50.3%	75° = 61.5%
8° = 57.6%	42° = 50.6%	76° = 61.8%
9° = 57.3%	43° = 50.9%	77° = 62.1%
10° = 57.0%	44° = 51.2%	78° = 62.4%
11° = 56.8%	45° = 51.5%	79° = 62.7%
12° = 56.6%	46° = 51.8%	80° = 63.0%
13° = 56.4%	47° = 52.1%	81° = 63.4%
14° = 56.2%	48° = 52.4%	82° = 63.8%
15° = 56.0%	49° = 52.7%	83° = 64.2%
16° = 55.8%	50° = 53.0%	84° = 64.6%
17° = 55.6%	51° = 53.4%	85° = 65.0%
18° = 55.4%	52° = 53.8%	86° = 65.4%
19° = 55.2%	53° = 54.2%	87° = 65.8%
20° = 55.0%	54° = 54.6%	88° = 66.2%
21° = 54.8%	55° = 55.0%	89° = 66.6%
22° = 54.6%	56° = 55.4%	90° = 67.0%
23° = 54.4%	57° = 55.8%	91° = 67.3%
24° = 54.2%	58° = 56.2%	92° = 67.6%
25° = 54.0%	59° = 56.6%	93° = 67.9%
26° = 53.8%	60° = 57.0%	94° = 68.2%
27° = 53.6%	61° = 57.3%	95° = 68.5%
28° = 53.4%	62° = 57.6%	96° = 68.8%
29° = 53.2%	63° = 57.9%	97° = 69.1%
30° = 53.0%	64° = 58.2%	98° = 69.4%
31° = 52.7%	65° = 58.5%	99° = 69.7%
32° = 52.4%	66° = 58.8%	100° = 70.0%
33° = 52.1%	67° = 59.1%	

(7) The following ratings are for loss of flexion at the metacarpophalangeal joint of any finger:

Retained Motion/Percentage of Impairment

0° = 55.0%	30° = 37.0%	60° = 18.0%
1° = 54.4%	31° = 36.4%	61° = 17.4%
2° = 53.8%	32° = 35.8%	62° = 16.8%
3° = 53.2%	33° = 35.2%	63° = 16.2%
4° = 52.6%	34° = 34.6%	64° = 15.6%
5° = 52.0%	35° = 34.0%	65° = 15.0%
6° = 51.4%	36° = 33.4%	66° = 14.4%
7° = 50.8%	37° = 32.8%	67° = 13.8%
8° = 50.2%	38° = 32.2%	68° = 13.2%
9° = 49.6%	39° = 31.6%	69° = 12.6%
10° = 49.0%	40° = 31.0%	70° = 12.0%
11° = 48.4%	41° = 30.3%	71° = 11.4%
12° = 47.8%	42° = 29.6%	72° = 10.8%
13° = 47.2%	43° = 28.9%	73° = 10.2%
14° = 46.6%	44° = 28.2%	74° = 9.6%
15° = 46.0%	45° = 27.5%	75° = 9.0%
16° = 45.4%	46° = 26.8%	76° = 8.4%
17° = 44.8%	47° = 26.1%	77° = 7.8%
18° = 44.2%	48° = 25.4%	78° = 7.2%
19° = 43.6%	49° = 24.7%	79° = 6.6%
20° = 43.0%	50° = 24.0%	80° = 6.0%
21° = 42.4%	51° = 23.4%	81° = 5.4%
22° = 41.8%	52° = 22.8%	82° = 4.8%
23° = 41.2%	53° = 22.2%	83° = 4.2%
24° = 40.6%	54° = 21.6%	84° = 3.6%
25° = 40.0%	55° = 21.0%	85° = 3.0%
26° = 39.4%	56° = 20.4%	86° = 2.4%
27° = 38.8%	57° = 19.8%	87° = 1.8%
28° = 38.2%	58° = 19.2%	88° = 1.2%
29° = 37.6%	59° = 18.6%	89° = 0.6%
		90° = 0.0%

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(8) The following ratings are for loss of extension at the metacarpophalangeal joint of any finger:

Retained Motion/Percentage of Impairment

0° = 0.0%	30° = 8.0%	60° = 54.0%
1° = 0.3%	31° = 9.5%	61° = 55.6%
2° = 0.6%	32° = 11.0%	62° = 57.2%
3° = 0.9%	33° = 12.5%	63° = 58.8%
4° = 1.2%	34° = 14.0%	64° = 60.4%
5° = 1.5%	35° = 15.5%	65° = 62.0%
6° = 1.8%	36° = 17.0%	66° = 63.6%
7° = 2.1%	37° = 18.5%	67° = 65.2%
8° = 2.4%	38° = 20.0%	68° = 66.8%
9° = 2.7%	39° = 21.5%	69° = 68.4%
10° = 3.0%	40° = 23.0%	70° = 70.0%
11° = 3.2%	41° = 24.6%	71° = 71.5%
12° = 3.4%	42° = 26.2%	72° = 73.0%
13° = 3.6%	43° = 27.8%	73° = 74.5%
14° = 3.8%	44° = 29.4%	74° = 76.0%
15° = 4.0%	45° = 31.0%	75° = 77.5%
16° = 4.2%	46° = 32.6%	76° = 79.0%
17° = 4.4%	47° = 34.2%	77° = 80.5%
18° = 4.6%	48° = 35.8%	78° = 82.0%
19° = 4.8%	49° = 37.4%	79° = 83.5%
20° = 5.0%	50° = 39.0%	80° = 85.0%
21° = 5.3%	51° = 40.5%	81° = 86.5%
22° = 5.6%	52° = 42.0%	82° = 88.0%
23° = 5.9%	53° = 43.5%	83° = 89.5%
24° = 6.2%	54° = 45.0%	84° = 91.0%
25° = 6.5%	55° = 46.5%	85° = 92.5%
26° = 6.8%	56° = 48.0%	86° = 94.0%
27° = 7.1%	57° = 49.5%	87° = 95.5%
28° = 7.4%	58° = 51.0%	88° = 97.0%
29° = 7.7%	59° = 52.5%	89° = 98.5%
		90° = 100.0%

(9) The following ratings are for ankylosis in the metacarpophalangeal joint of any finger:

Joint Ankylosed at/Percentage of Impairment

0° = 55.0%	30° = 45.0%	60° = 72.0%
1° = 54.7%	31° = 45.9%	61° = 73.0%
2° = 54.4%	32° = 46.8%	62° = 74.0%
3° = 54.1%	33° = 47.7%	63° = 75.0%
4° = 53.8%	34° = 48.6%	64° = 76.0%
5° = 53.5%	35° = 49.5%	65° = 77.0%
6° = 53.2%	36° = 50.4%	66° = 78.0%
7° = 52.9%	37° = 51.3%	67° = 79.0%
8° = 52.6%	38° = 52.2%	68° = 80.0%
9° = 52.3%	39° = 53.1%	69° = 81.0%
10° = 52.0%	40° = 54.0%	70° = 82.0%
11° = 51.6%	41° = 54.9%	71° = 82.9%
12° = 51.2%	42° = 55.8%	72° = 83.8%
13° = 50.8%	43° = 56.7%	73° = 84.7%
14° = 50.4%	44° = 57.6%	74° = 85.6%

15° = 50.0%	45° = 58.5%	75° = 86.5%
16° = 49.6%	46° = 59.4%	76° = 87.4%
17° = 49.2%	47° = 60.3%	77° = 88.3%
18° = 48.8%	48° = 61.2%	78° = 89.2%
19° = 48.4%	49° = 62.1%	79° = 90.1%
20° = 48.0%	50° = 63.0%	80° = 91.0%
21° = 47.7%	51° = 63.9%	81° = 91.9%
22° = 47.4%	52° = 64.8%	82° = 92.8%
23° = 47.1%	53° = 65.7%	83° = 93.7%
24° = 46.8%	54° = 66.6%	84° = 94.6%
25° = 46.5%	55° = 67.5%	85° = 95.5%
26° = 46.2%	56° = 68.4%	86° = 96.4%
27° = 45.9%	57° = 69.3%	87° = 97.3%
28° = 45.6%	58° = 70.2%	88° = 98.2%
29° = 45.3%	59° = 71.1%	89° = 99.1%
		90° = 100.0%

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 5/5/10 as WCD Admin. Order 10-051, eff. 6/1/10

436-035-0070 Conversion of Thumb/Finger Values to Hand Value

(1) Loss of use of two or more digits is converted to a value for loss in the hand if the worker will receive more money for the conversion. At least two digits must have impairment other than loss of opposition to qualify for conversion to hand.

(2) When converting impairment values of digits to hand values, the applicable hand impairment is determined by rating the total impairment value in each digit under OAR 436-035-0011(2)(b), then converting the digit values to hand values, and then adding the converted values. Digit values between zero and one are rounded to one prior to conversion.

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(3) The following table is used to convert loss in the thumb to loss in the hand:

Impairment of Thumb Hand	Impairment of Thumb Hand
1- 3% = 1%	51-53% = 17%
4- 6% = 2%	54-56% = 18%
7- 9% = 3%	57-59% = 19%
10-12% = 4%	60-62% = 20%
13-15% = 5%	63-65% = 21%
16-18% = 6%	66-68% = 22%
19-21% = 7%	69-71% = 23%
22-25% = 8%	72-75% = 24%
26-28% = 9%	76-78% = 25%
29-31% = 10%	79-81% = 26%
32-34% = 11%	82-84% = 27%
35-37% = 12%	85-87% = 28%
38-40% = 13%	88-90% = 29%
41-43% = 14%	91-93% = 30%
44-46% = 15%	94-96% = 31%
47-50% = 16%	97-100% = 32%

(4) The following table is used to convert loss in the index finger to loss in the hand:

Impairment of Index Hand	Impairment of Index Hand
1- 6% = 1%	51-56% = 9%
7-12% = 2%	57-62% = 10%
13-18% = 3%	63-68% = 11%
19-25% = 4%	69-75% = 12%
26-31% = 5%	76-81% = 13%
32-37% = 6%	82-87% = 14%
38-43% = 7%	88-93% = 15%
44-50% = 8%	94-100% = 16%

(5) The following table is used to convert loss in the middle finger to loss in the hand:

Impairment of Middle Hand	Impairment of Middle Hand
1- 6% = 1%	55-61% = 9%
7-13% = 2%	62-68% = 10%
14-20% = 3%	69-75% = 11%
21-27% = 4%	76-81% = 12%
28-34% = 5%	82-88% = 13%
35-40% = 6%	89-95% = 14%
41-47% = 7%	96-100% = 15%
48-54% = 8%	

(6) The following table is used to convert loss in the ring finger to loss in the hand:

Impairment of Ring Hand
1- 15% = 1%
16-30% = 2%
31-45% = 3%
46-59% = 4%
60-74% = 5%
75-89% = 6%
90-100% = 7%

(7) The following table is used to convert loss in the little finger to loss in the hand:

Impairment of Little Hand
1-25% = 1%
26-50% = 2%
51-75% = 3%
76-100% = 4%

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 10/26/04 as WCD Admin. Order 04-063, eff 1/1/05

436-035-0075 Hand

(1) Under OAR 436-035-0020(3), the ratings in this section are hand values. Abduction and adduction of the carpometacarpal joint of the thumb are associated with the ability to extend and flex. This association has been taken into consideration in establishing the percentages of impairment.

(2) The following ratings are for loss of flexion (adduction) of the carpometacarpal joint of the thumb:

Retained Motion/Percentage of Impairment

0° = 6.0%	5° = 4.0%	10° = 2.0%
1° = 5.6%	6° = 3.6%	11° = 1.6%
2° = 5.2%	7° = 3.2%	12° = 1.2%
3° = 4.8%	8° = 2.8%	13° = 0.8%
4° = 4.4%	9° = 2.4%	14° = 0.4%
		15° = 0.0%

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(3) The following ratings are for loss of extension (abduction) of the carpometacarpal joint of the thumb:

Retained Motion/Percentage of Impairment

0° = 6.0%	10° = 4.0%	20° = 2.0%
1° = 5.8%	11° = 3.8%	21° = 1.8%
2° = 5.6%	12° = 3.6%	22° = 1.6%
3° = 5.4%	13° = 3.4%	23° = 1.4%
4° = 5.2%	14° = 3.2%	24° = 1.2%
5° = 5.0%	15° = 3.0%	25° = 1.0%
6° = 4.8%	16° = 2.8%	26° = 0.8%
7° = 4.6%	17° = 2.6%	27° = 0.6%
8° = 4.4%	18° = 2.4%	28° = 0.4%
9° = 4.2%	19° = 2.2%	29° = 0.2%
		30° = 0.0%

(4) The following ratings are for ankylosis of the carpometacarpal joint in flexion (adduction) of the thumb:

Joint Ankylosed at/Percentage of Impairment

0° = 12%	8° = 20%
1° = 13%	9° = 21%
2° = 14%	10° = 22%
3° = 15%	11° = 24%
4° = 16%	12° = 26%
5° = 17%	13° = 28%
6° = 18%	14° = 30%
7° = 19%	15° = 32%

(5) The following ratings are for ankylosis of the carpometacarpal joint in extension (abduction) of the thumb:

Joint Ankylosed at/Percentage of Impairment

0° = 12.0%	10° = 19.0%	20° = 25.0%
1° = 12.7%	11° = 19.6%	21° = 25.7%
2° = 13.4%	12° = 20.2%	22° = 26.4%
3° = 14.1%	13° = 20.8%	23° = 27.1%
4° = 14.8%	14° = 21.4%	24° = 27.8%
5° = 15.5%	15° = 22.0%	25° = 28.5%
6° = 16.2%	16° = 22.6%	26° = 29.2%
7° = 16.9%	17° = 23.2%	27° = 29.9%
8° = 17.6%	18° = 23.8%	28° = 30.6%
9° = 18.3%	19° = 24.4%	29° = 31.3%
		30° = 32.0%

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726

Hist.: Amended 10/26/04 as WCD Admin. Order 04-063, eff 1/1/05

436-035-0080 Wrist

(1) The following ratings are for loss of (dorsiflexion) extension at the wrist joint:

Retained Motion/Percentage of Impairment

0° = 10.0%	20° = 6.0%	40° = 3.0%
1° = 9.8%	21° = 5.9%	41° = 2.9%
2° = 9.6%	22° = 5.8%	42° = 2.8%
3° = 9.4%	23° = 5.7%	43° = 2.7%
4° = 9.2%	24° = 5.6%	44° = 2.6%
5° = 9.0%	25° = 5.5%	45° = 2.5%
6° = 8.8%	26° = 5.4%	46° = 2.4%
7° = 8.6%	27° = 5.3%	47° = 2.3%
8° = 8.4%	28° = 5.2%	48° = 2.2%
9° = 8.2%	29° = 5.1%	49° = 2.1%
10° = 8.0%	30° = 5.0%	50° = 2.0%
11° = 7.8%	31° = 4.8%	51° = 1.8%
12° = 7.6%	32° = 4.6%	52° = 1.6%
13° = 7.4%	33° = 4.4%	53° = 1.4%
14° = 7.2%	34° = 4.2%	54° = 1.2%
15° = 7.0%	35° = 4.0%	55° = 1.0%
16° = 6.8%	36° = 3.8%	56° = 0.8%
17° = 6.6%	37° = 3.6%	57° = 0.6%
18° = 6.4%	38° = 3.4%	58° = 0.4%
19° = 6.2%	39° = 3.2%	59° = 0.2%
		60° = 0.0%

(2) The following ratings are for (dorsiflexion) extension ankylosis in the wrist joint:

Joint Ankylosed at/Percentage of Impairment

0° = 30.0%	20° = 27.0%	40° = 47.0%
1° = 29.8%	21° = 26.8%	41° = 49.1%
2° = 29.6%	22° = 26.6%	42° = 51.2%
3° = 29.4%	23° = 26.4%	43° = 53.3%
4° = 29.2%	24° = 26.2%	44° = 55.4%
5° = 29.0%	25° = 26.0%	45° = 57.5%
6° = 28.8%	26° = 25.8%	46° = 59.6%
7° = 28.6%	27° = 25.6%	47° = 61.7%
8° = 28.4%	28° = 25.4%	48° = 63.8%
9° = 28.2%	29° = 25.2%	49° = 65.9%
10° = 28.0%	30° = 25.0%	50° = 68.0%
11° = 27.9%	31° = 27.2%	51° = 70.2%
12° = 27.8%	32° = 29.4%	52° = 72.4%
13° = 27.7%	33° = 31.6%	53° = 74.6%
14° = 27.6%	34° = 33.8%	54° = 76.8%
15° = 27.5%	35° = 36.0%	55° = 79.0%
16° = 27.4%	36° = 38.2%	56° = 81.2%
17° = 27.3%	37° = 40.4%	57° = 83.4%
18° = 27.2%	38° = 42.6%	58° = 85.6%
19° = 27.1%	39° = 44.8%	59° = 87.8%
		60° = 90.0%

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(3) The following ratings are for loss of (palmar) flexion in the wrist joint:

Retained Motion/Percentage of Impairment

0° = 11.0%	24° = 7.2%	48° = 3.4%
1° = 10.9%	25° = 7.0%	49° = 3.2%
2° = 10.8%	26° = 6.8%	50° = 3.0%
3° = 10.7%	27° = 6.6%	51° = 2.9%
4° = 10.6%	28° = 6.4%	52° = 2.8%
5° = 10.5%	29° = 6.2%	53° = 2.7%
6° = 10.4%	30° = 6.0%	54° = 2.6%
7° = 10.3%	31° = 5.9%	55° = 2.5%
8° = 10.2%	32° = 5.8%	56° = 2.4%
9° = 10.1%	33° = 5.7%	57° = 2.3%
10° = 10.0%	34° = 5.6%	58° = 2.2%
11° = 9.8%	35° = 5.5%	59° = 2.1%
12° = 9.6%	36° = 5.4%	60° = 2.0%
13° = 9.4%	37° = 5.3%	61° = 1.8%
14° = 9.2%	38° = 5.2%	62° = 1.6%
15° = 9.0%	39° = 5.1%	63° = 1.4%
16° = 8.8%	40° = 5.0%	64° = 1.2%
17° = 8.6%	41° = 4.8%	65° = 1.0%
18° = 8.4%	42° = 4.6%	66° = 0.8%
19° = 8.2%	43° = 4.4%	67° = 0.6%
20° = 8.0%	44° = 4.2%	68° = 0.4%
21° = 7.8%	45° = 4.0%	69° = 0.2%
22° = 7.6%	46° = 3.8%	70° = 0.0%
23° = 7.4%	47° = 3.6%	

(4) The following ratings are for (palmar) flexion ankylosis in the wrist joint:

Joint Ankylosed at/Percentage of Impairment

0° = 30.0%	24° = 50.6%	48° = 71.2%
1° = 30.9%	25° = 51.5%	49° = 72.1%
2° = 31.8%	26° = 52.4%	50° = 73.0%
3° = 32.7%	27° = 53.3%	51° = 73.8%
4° = 33.6%	28° = 54.2%	52° = 74.6%
5° = 34.5%	29° = 55.1%	53° = 75.4%
6° = 35.4%	30° = 56.0%	54° = 76.2%
7° = 36.3%	31° = 56.8%	55° = 77.0%
8° = 37.2%	32° = 57.6%	56° = 77.8%
9° = 38.1%	33° = 58.4%	57° = 78.6%
10° = 39.0%	34° = 59.2%	58° = 79.4%
11° = 39.8%	35° = 60.0%	59° = 80.2%
12° = 40.6%	36° = 60.8%	60° = 81.0%
13° = 41.4%	37° = 61.6%	61° = 81.9%
14° = 42.2%	38° = 62.4%	62° = 82.8%
15° = 43.0%	39° = 63.2%	63° = 83.7%
16° = 43.8%	40° = 64.0%	64° = 84.6%
17° = 44.6%	41° = 64.9%	65° = 85.5%
18° = 45.4%	42° = 65.8%	66° = 86.4%
19° = 46.2%	43° = 66.7%	67° = 87.3%
20° = 47.0%	44° = 67.6%	68° = 88.2%
21° = 47.9%	45° = 68.5%	69° = 89.1%
22° = 48.8%	46° = 69.4%	70° = 90.0%

23° = 49.7%	47° = 70.3%	
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(5) The following ratings are for loss of radial deviation in the wrist joint:

Retained Motion/Percentage of Impairment

0° = 4.0%	7° = 2.6%	14° = 1.2%
1° = 3.8%	8° = 2.4%	15° = 1.0%
2° = 3.6%	9° = 2.2%	16° = 0.8%
3° = 3.4%	10° = 2.0%	17° = 0.6%
4° = 3.2%	11° = 1.8%	18° = 0.4%
5° = 3.0%	12° = 1.6%	19° = 0.2%
6° = 2.8%	13° = 1.4%	20° = 0.0%

(6) The following ratings are for radial deviation ankylosis in the wrist joint:

Joint Ankylosed at/Percentage of Impairment

0° = 30%	7° = 51%	14° = 72%
1° = 33%	8° = 54%	15° = 75%
2° = 36%	9° = 57%	16° = 78%
3° = 39%	10° = 60%	17° = 81%
4° = 42%	11° = 63%	18° = 84%
5° = 45%	12° = 66%	19° = 87%
6° = 48%	13° = 69%	20° = 90%

(7) The following ratings are for loss of ulnar deviation in the wrist joint:

Retained Motion/Percentage of Impairment

0° = 5.0%	10° = 4.0%	20° = 2.0%
1° = 4.9%	11° = 3.8%	21° = 1.8%
2° = 4.8%	12° = 3.6%	22° = 1.6%
3° = 4.7%	13° = 3.4%	23° = 1.4%
4° = 4.6%	14° = 3.2%	24° = 1.2%
5° = 4.5%	15° = 3.0%	25° = 1.0%
6° = 4.4%	16° = 2.8%	26° = 0.8%
7° = 4.3%	17° = 2.6%	27° = 0.6%
8° = 4.2%	18° = 2.4%	28° = 0.4%
9° = 4.1%	19° = 2.2%	29° = 0.2%
		30° = 0.0%

(8) The following ratings are for ulnar deviation ankylosis in the wrist joint:

Joint Ankylosed at/Percentage of Impairment

0° = 30%	10° = 50%	20° = 70%
1° = 32%	11° = 52%	21° = 72%
2° = 34%	12° = 54%	22° = 74%
3° = 36%	13° = 56%	23° = 76%
4° = 38%	14° = 58%	24° = 78%
5° = 40%	15° = 60%	25° = 80%
6° = 42%	16° = 62%	26° = 82%
7° = 44%	17° = 64%	27° = 84%
8° = 46%	18° = 66%	28° = 86%
9° = 48%	19° = 68%	29° = 88%
		30° = 90%

(9) Injuries which result in a loss of pronation or supination in the wrist joint are valued under OAR 436-035-0100(4).

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 10/26/04 as WCD Admin. Order 04-063, eff 1/1/05

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436-035-0090 Conversion of Hand/Forearm Values to Arm Values

The following table is used to convert a loss in the hand/forearm to a loss in the arm:

Impairment of Hand Arm	Impairment of Hand Arm	Impairment of Hand Arm
1% = 1%	34% = 27%	67% = 53%
2% = 2%	35% = 28%	68% = 54%
3% = 3%	36% = 29%	69% = 55%
4% = 4%	37% = 30%	70% = 56%
5% = 4%	38% = 31%	71% = 57%
6% = 5%	39% = 31%	72% = 57%
7% = 6%	40% = 32%	73% = 58%
8% = 7%	41% = 33%	74% = 59%
9% = 8%	42% = 34%	75% = 60%
10% = 8%	43% = 34%	76% = 61%
11% = 9%	44% = 35%	77% = 61%
12% = 10%	45% = 36%	78% = 62%
13% = 11%	46% = 37%	79% = 63%
14% = 12%	47% = 38%	80% = 64%
15% = 12%	48% = 38%	81% = 64%
16% = 13%	49% = 39%	82% = 65%
17% = 14%	50% = 40%	83% = 66%
18% = 15%	51% = 41%	84% = 67%
19% = 16%	52% = 42%	85% = 68%
20% = 16%	53% = 42%	86% = 68%
21% = 17%	54% = 43%	87% = 69%
22% = 18%	55% = 44%	88% = 70%
23% = 19%	56% = 45%	89% = 71%
24% = 20%	57% = 46%	90% = 72%
25% = 20%	58% = 46%	91% = 72%
26% = 21%	59% = 47%	92% = 73%
27% = 22%	60% = 48%	93% = 74%
28% = 23%	61% = 49%	94% = 75%
29% = 23%	62% = 49%	95% = 76%
30% = 24%	63% = 50%	96% = 76%
31% = 25%	64% = 51%	97% = 77%
32% = 26%	65% = 52%	98% = 78%
33% = 27%	66% = 53%	99% = 79%
		100% = 79%

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 10-26-04 as WCD Admin. Order 04-063, eff 1/1/05

436-035-0100 Arm

(1) The following ratings are for loss of flexion in the elbow joint (150° describes the arm in full flexion):

Retained Motion/Percentage of Impairment

0° = 39.0%	38° = 29.4%	76° = 19.2%	114° = 9.2%
1° = 38.7%	39° = 29.2%	77° = 18.9%	115° = 9.0%
2° = 38.4%	40° = 29.0%	78° = 18.6%	116° = 8.8%
3° = 38.1%	41° = 28.7%	79° = 18.3%	117° = 8.6%
4° = 37.8%	42° = 28.4%	80° = 18.0%	118° = 8.4%
5° = 37.5%	43° = 28.1%	81° = 17.8%	119° = 8.2%
6° = 37.2%	44° = 27.8%	82° = 17.6%	120° = 8.0%
7° = 36.9%	45° = 27.5%	83° = 17.4%	121° = 7.7%
8° = 36.6%	46° = 27.2%	84° = 17.2%	122° = 7.4%
9° = 36.3%	47° = 26.9%	85° = 17.0%	123° = 7.1%
10° = 36.0%	48° = 26.6%	86° = 16.8%	124° = 6.8%
11° = 35.8%	49° = 26.3%	87° = 16.6%	125° = 6.5%
12° = 35.6%	50° = 26.0%	88° = 16.4%	126° = 6.2%
13° = 35.4%	51° = 25.7%	89° = 16.2%	127° = 5.9%
14° = 35.2%	52° = 25.4%	90° = 16.0%	128° = 5.6%
15° = 35.0%	53° = 25.1%	91° = 15.7%	129° = 5.3%
16° = 34.8%	54° = 24.8%	92° = 15.4%	130° = 5.0%
17° = 34.6%	55° = 24.5%	93° = 15.1%	131° = 4.8%
18° = 34.4%	56° = 24.2%	94° = 14.8%	132° = 4.6%
19° = 34.2%	57° = 23.9%	95° = 14.5%	133° = 4.4%
20° = 34.0%	58° = 23.6%	96° = 14.2%	134° = 4.2%
21° = 33.7%	59° = 23.3%	97° = 13.9%	135° = 4.0%
22° = 33.4%	60° = 23.0%	98° = 13.6%	136° = 3.8%
23° = 33.1%	61° = 22.8%	99° = 13.3%	137° = 3.6%
24° = 32.8%	62° = 22.6%	100° = 13.0%	138° = 3.4%
25° = 32.5%	63° = 22.4%	101° = 12.7%	139° = 3.2%
26° = 32.2%	64° = 22.2%	102° = 12.4%	140° = 3.0%
27° = 31.9%	65° = 22.0%	103° = 12.1%	141° = 2.7%
28° = 31.6%	66° = 21.8%	104° = 11.8%	142° = 2.4%
29° = 31.3%	67° = 21.6%	105° = 11.5%	143° = 2.1%
30° = 31.0%	68° = 21.4%	106° = 11.2%	144° = 1.8%
31° = 30.8%	69° = 21.2%	107° = 10.9%	145° = 1.5%
32° = 30.6%	70° = 21.0%	108° = 10.6%	146° = 1.2%
33° = 30.4%	71° = 20.7%	109° = 10.3%	147° = 0.9%
34° = 30.2%	72° = 20.4%	110° = 10.0%	148° = 0.6%
35° = 30.0%	73° = 20.1%	111° = 9.8%	149° = 0.3%
36° = 29.8%	74° = 19.8%	112° = 9.6%	150° = 0.0%
37° = 29.6%	75° = 19.5%	113° = 9.4%	

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(2) The following ratings are for loss of extension in the elbow joint (0° describes the arm in full extension):

Retained Motion/Percentage of Impairment

0° = 0.0%	38° = 7.6%	76° = 15.2%	114° = 22.8%
1° = 0.2%	39° = 7.8%	77° = 15.4%	115° = 23.0%
2° = 0.4%	40° = 8.0%	78° = 15.6%	116° = 23.2%
3° = 0.6%	41° = 8.2%	79° = 15.8%	117° = 23.4%
4° = 0.8%	42° = 8.4%	80° = 16.0%	118° = 23.6%
5° = 1.0%	43° = 8.6%	81° = 16.2%	119° = 23.8%
6° = 1.2%	44° = 8.8%	82° = 16.4%	120° = 24.0%
7° = 1.4%	45° = 9.0%	83° = 16.6%	121° = 24.2%
8° = 1.6%	46° = 9.2%	84° = 16.8%	122° = 24.4%
9° = 1.8%	47° = 9.4%	85° = 17.0%	123° = 24.6%
10° = 2.0%	48° = 9.6%	86° = 17.2%	124° = 24.8%
11° = 2.2%	49° = 9.8%	87° = 17.4%	125° = 25.0%
12° = 2.4%	50° = 10.0%	88° = 17.6%	126° = 25.2%
13° = 2.6%	51° = 10.2%	89° = 17.8%	127° = 25.4%
14° = 2.8%	52° = 10.4%	90° = 18.0%	128° = 25.6%
15° = 3.0%	53° = 10.6%	91° = 18.2%	129° = 25.8%
16° = 3.2%	54° = 10.8%	92° = 18.4%	130° = 26.0%
17° = 3.4%	55° = 11.0%	93° = 18.6%	131° = 26.2%
18° = 3.6%	56° = 11.2%	94° = 18.8%	132° = 26.4%
19° = 3.8%	57° = 11.4%	95° = 19.0%	133° = 26.6%
20° = 4.0%	58° = 11.6%	96° = 19.2%	134° = 26.8%
21° = 4.2%	59° = 11.8%	97° = 19.4%	135° = 27.0%
22° = 4.4%	60° = 12.0%	98° = 19.6%	136° = 27.2%
23° = 4.6%	61° = 12.2%	99° = 19.8%	137° = 27.4%
24° = 4.8%	62° = 12.4%	100° = 20.0%	138° = 27.6%
25° = 5.0%	63° = 12.6%	101° = 20.2%	139° = 27.8%
26° = 5.2%	64° = 12.8%	102° = 20.4%	140° = 28.0%
27° = 5.4%	65° = 13.0%	103° = 20.6%	141° = 28.2%
28° = 5.6%	66° = 13.2%	104° = 20.8%	142° = 28.4%
29° = 5.8%	67° = 13.4%	105° = 21.0%	143° = 28.6%
30° = 6.0%	68° = 13.6%	106° = 21.2%	144° = 28.8%
31° = 6.2%	69° = 13.8%	107° = 21.4%	145° = 29.0%
32° = 6.4%	70° = 14.0%	108° = 21.6%	146° = 29.2%
33° = 6.6%	71° = 14.2%	109° = 21.8%	147° = 29.4%
34° = 6.8%	72° = 14.4%	110° = 22.0%	148° = 29.6%
35° = 7.0%	73° = 14.6%	111° = 22.2%	149° = 29.8%
36° = 7.2%	74° = 14.8%	112° = 22.4%	150° = 30.0%
37° = 7.4%	75° = 15.0%	113° = 22.6%	

(3) Ankylosis of the elbow in flexion or extension is rated as follows:

Joint Ankylosed at/Percentage of Impairment

0° = 65.0%	38° = 59.4%	76° = 53.8%	114° = 62.6%
1° = 64.9%	39° = 59.2%	77° = 53.6%	115° = 63.5%
2° = 64.8%	40° = 59.0%	78° = 53.4%	116° = 64.4%
3° = 64.7%	41° = 58.9%	79° = 53.2%	117° = 65.3%
4° = 64.6%	42° = 58.8%	80° = 53.0%	118° = 66.2%
5° = 64.5%	43° = 58.7%	81° = 52.9%	119° = 67.1%
6° = 64.4%	44° = 58.6%	82° = 52.8%	120° = 68.0%
7° = 64.3%	45° = 58.5%	83° = 52.7%	121° = 68.9%
8° = 64.2%	46° = 58.4%	84° = 52.6%	122° = 69.8%
9° = 64.1%	47° = 58.3%	85° = 52.5%	123° = 70.7%
10° = 64.0%	48° = 58.2%	86° = 52.4%	124° = 71.6%
11° = 63.8%	49° = 58.1%	87° = 52.3%	125° = 72.5%
12° = 63.6%	50° = 58.0%	88° = 52.2%	126° = 73.4%
13° = 63.4%	51° = 57.8%	89° = 52.1%	127° = 74.3%
14° = 63.2%	52° = 57.6%	90° = 52.0%	128° = 75.2%
15° = 63.0%	53° = 57.4%	91° = 51.8%	129° = 76.1%
16° = 62.8%	54° = 57.2%	92° = 51.6%	130° = 77.0%
17° = 62.6%	55° = 57.0%	93° = 51.4%	131° = 77.9%
18° = 62.4%	56° = 56.8%	94° = 51.2%	132° = 78.8%
19° = 62.2%	57° = 56.6%	95° = 51.0%	133° = 79.7%
20° = 62.0%	58° = 56.4%	96° = 50.8%	134° = 80.6%
21° = 61.9%	59° = 56.2%	97° = 50.6%	135° = 81.5%
22° = 61.8%	60° = 56.0%	98° = 50.4%	136° = 82.4%
23° = 61.7%	61° = 55.9%	99° = 50.2%	137° = 83.3%
24° = 61.6%	62° = 55.8%	100° = 50.0%	138° = 84.2%
25° = 61.5%	63° = 55.7%	101° = 50.9%	139° = 85.1%
26° = 61.4%	64° = 55.6%	102° = 51.8%	140° = 86.0%
27° = 61.3%	65° = 55.5%	103° = 52.7%	141° = 86.9%
28° = 61.2%	66° = 55.4%	104° = 53.6%	142° = 87.8%
29° = 61.1%	67° = 55.3%	105° = 54.5%	143° = 88.7%
30° = 61.0%	68° = 55.2%	106° = 55.4%	144° = 89.6%
31° = 60.8%	69° = 55.1%	107° = 56.3%	145° = 90.5%
32° = 60.6%	70° = 55.0%	108° = 57.2%	146° = 91.4%
33° = 60.4%	71° = 54.8%	109° = 58.1%	147° = 92.3%
34° = 60.2%	72° = 54.6%	110° = 59.0%	148° = 93.2%
35° = 60.0%	73° = 54.4%	111° = 59.9%	149° = 94.1%
36° = 59.8%	74° = 54.2%	112° = 60.8%	150° = 95.0%
37° = 59.6%	75° = 54.0%	113° = 61.7%	

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(4) The following ratings are for loss of pronation or supination in the elbow joint. If there are losses in both pronation and supination, rate each separately and add the values:

Retained Motion/Percentage of Impairment

0° = 13.0%	27° = 8.6%	54° = 4.2%
1° = 12.8%	28° = 8.4%	55° = 4.0%
2° = 12.6%	29° = 8.2%	56° = 3.8%
3° = 12.4%	30° = 8.0%	57° = 3.6%
4° = 12.2%	31° = 7.9%	58° = 3.4%
5° = 12.0%	32° = 7.8%	59° = 3.2%
6° = 11.8%	33° = 7.7%	60° = 3.0%
7° = 11.6%	34° = 7.6%	61° = 2.9%
8° = 11.4%	35° = 7.5%	62° = 2.8%
9° = 11.2%	36° = 7.4%	63° = 2.7%
10° = 11.0%	37° = 7.3%	64° = 2.6%
11° = 10.9%	38° = 7.2%	65° = 2.5%
12° = 10.8%	39° = 7.1%	66° = 2.4%
13° = 10.7%	40° = 7.0%	67° = 2.3%
14° = 10.6%	41° = 6.8%	68° = 2.2%
15° = 10.5%	42° = 6.6%	69° = 2.1%
16° = 10.4%	43° = 6.4%	70° = 2.0%
17° = 10.3%	44° = 6.2%	71° = 1.8%
18° = 10.2%	45° = 6.0%	72° = 1.6%
19° = 10.1%	46° = 5.8%	73° = 1.4%
20° = 10.0%	47° = 5.6%	74° = 1.2%
21° = 9.8%	48° = 5.4%	75° = 1.0%
22° = 9.6%	49° = 5.2%	76° = 0.8%
23° = 9.4%	50° = 5.0%	77° = 0.6%
24° = 9.2%	51° = 4.8%	78° = 0.4%
25° = 9.0%	52° = 4.6%	79° = 0.2%
26° = 8.8%	53° = 4.4%	80° = 0.0%

(5) Ankylosis of the elbow in pronation or supination will be rated as follows:

Joint Ankylosed at/Percentage of Impairment

0° = 65.0%	27° = 75.1%	54° = 85.6%
1° = 65.4%	28° = 75.4%	55° = 86.0%
2° = 65.8%	29° = 75.7%	56° = 86.4%
3° = 66.2%	30° = 76.0%	57° = 86.8%
4° = 66.6%	31° = 76.4%	58° = 87.2%
5° = 67.0%	32° = 76.8%	59° = 87.6%
6° = 67.4%	33° = 77.2%	60° = 88.0%
7° = 67.8%	34° = 77.6%	61° = 88.3%
8° = 68.2%	35° = 78.0%	62° = 88.6%
9° = 68.6%	36° = 78.4%	63° = 88.9%
10° = 69.0%	37° = 78.8%	64° = 89.2%
11° = 69.4%	38° = 79.2%	65° = 89.5%
12° = 69.8%	39° = 79.6%	66° = 89.8%
13° = 70.2%	40° = 80.0%	67° = 90.1%
14° = 70.6%	41° = 80.4%	68° = 90.4%
15° = 71.0%	42° = 80.8%	69° = 90.7%
16° = 71.4%	43° = 81.2%	70° = 91.0%
17° = 71.8%	44° = 81.6%	71° = 91.4%
18° = 72.2%	45° = 82.0%	72° = 91.8%
19° = 72.6%	46° = 82.4%	73° = 92.2%
20° = 73.0%	47° = 82.8%	74° = 92.6%
21° = 73.3%	48° = 83.2%	75° = 93.0%
22° = 73.6%	49° = 83.6%	76° = 93.4%
23° = 73.9%	50° = 84.0%	77° = 93.8%
24° = 74.2%	51° = 84.4%	78° = 94.2%
25° = 74.5%	52° = 84.8%	79° = 94.6%
26° = 74.8%	53° = 85.2%	80° = 95.0%

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 10/26/04 as WCD Admin. Order 04-063, eff 1/1/05

436-035-0110 Other Upper Extremity Findings

(1) Loss of palmar sensation in the hand, finger(s), or thumb is rated based on the location and quality of the loss, and is measured by the two-point discrimination method.

(a) Sensation is determined by using any instrumentation that allows for measuring the distance between two pin pricks applied at the same time (two-point) and using the following procedure:

(A) With the worker's eyes closed, the examiner touches the tip of the instrument to the digit in the longitudinal axis on the radial or ulnar side.

(B) The worker indicates whether one or two points are felt.

(C) A varied series of one or two points are applied.

(D) Testing is started distally and proceeds proximally to determine the longitudinal level of involvement.

(E) The ends of the testing device are set first at 15 mm apart and the distance is progressively decreased as accurate responses are obtained.

(F) The minimum distance at which the individual can accurately discriminate between one and two point tests in two out of three applications is recorded for each area.

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(b) If enough sensitivity remains to distinguish two pin pricks applied at the same time (two point), the following apply:

Finding	Grade of sensation
6 millimeters apart or less:	normal
7-10 millimeters:	less than normal
11-15 millimeters:	protective sensation
Greater than 15 millimeters:	total loss

(c) In determining sensation findings for a digit that has been resected or amputated, the value is established by comparing the remaining overall length of the digit to the table in subsection (1)(d) of this rule and rating the length equivalency.

For example: Amputation of 1/2 the middle phalanx of the index finger with total sensory loss extending from the level of amputation to the metacarpophalangeal joint, results in a value for 1/2 the digit or 33%.

(d) Loss of sensation in the finger(s) or thumb is rated as follows:

Level of loss and percentage of impairment						
	Whole digit MP joint	1/2 Proximal phalanx	PIP joint	1/2 Digit or IP joint of the thumb	DIP joint	1/2 Distal phalanx
Thumb						
Less than normal:	25	19	NA	12	NA	8
Radial side only:	10	8	NA	5	NA	3
Ulnar side only:	17	12	NA	7	NA	5
Protective sensation:	38	28	NA	17	NA	12
Radial side only:	17	12	NA	7	NA	5
Ulnar side only:	25	18	NA	11	NA	7
Total loss of sensation:	50	37	NA	23	NA	15
Radial side only:	23	16	NA	9	NA	6
Ulnar side only:	35	25	NA	15	NA	10
Index finger						
Less than normal:	25	23	20	17	13	8
Radial side only:	17	15	13	11	8	5
Ulnar side only:	10	9	8	7	5	3
Protective sensation:	38	35	30	25	19	12
Radial side only:	25	23	20	17	12	7
Ulnar side only:	17	15	13	10	8	5
Total loss of sensation:	50	45	39	33	24	15
Radial side only:	35	31	27	22	16	10
Ulnar side only:	23	20	17	14	10	6
Middle finger						
Less than normal:	25	23	20	17	13	8
Radial side only:	17	15	13	11	8	5
Ulnar side only:	10	9	8	7	5	3
Protective sensation:	38	35	30	25	19	12
Radial side only:	25	23	20	17	12	7
Ulnar side only:	17	15	13	10	8	5
Total loss of sensation:	50	45	39	33	24	15
Radial side only:	35	31	27	22	16	10
Ulnar side only:	23	20	17	14	10	6

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Level of loss and percentage of impairment						
	Whole digit MP joint	1/2 Proximal phalanx	PIP joint	1/2 Digit or IP joint of the thumb	DIP joint	1/2 Distal phalanx
Ring finger						
Less than normal:	25	23	20	17	13	8
Radial side only:	17	15	13	11	8	5
Ulnar side only:	10	9	8	7	5	3
Protective sensation:	38	35	30	25	19	12
Radial side only:	25	23	20	17	12	7
Ulnar side only:	17	15	13	10	8	5
Total loss of sensation:	50	45	39	33	24	15
Radial side only:	35	31	27	22	16	10
Ulnar side only:	23	20	17	14	10	6
Little finger						
Less than normal:	25	23	20	17	13	8
Radial side only:	10	9	8	7	5	3
Ulnar side only:	17	15	13	11	8	5
Protective sensation:	38	35	30	25	19	12
Radial side only:	17	15	13	10	8	5
Ulnar side only:	25	23	20	17	12	7
Total loss of sensation:	50	45	39	33	24	15
Radial side only:	23	20	17	14	10	6
Ulnar side only:	35	31	27	22	16	10
(NA = Not applicable)						

(e) If the level of the loss is less than 1/2 the distal phalanx or falls between the levels in subsection (d) of this section, rate at the next highest (or more proximal) level.

(f) In determining sensation impairment in a digit in which the sensation loss does not extend to the distal end of the digit, the value is established by determining the value for loss from the distal end of the digit to the proximal location of the loss, and subtracting the value for loss from the distal end of the digit to the distal location of the loss.

Example: Grade 2 sensation in the index finger between the PIP joint and the MP joint:

Loss from distal end of the finger to the MP joint (proximal location of loss) 25%

Minus loss from distal end of the finger to the PIP joint (distal location of loss) 20%

Equals loss between MP and PIP 5%

(g) Sensation loss on the palmar side of the hand is rated as follows:

	Total loss of sensation	Protective sensation
Palmar median nerve	15%	11%
Palmar ulnar nerve	7%	5%

(h) Loss of sensation or hypersensitivity on the dorsal side of the hand, fingers or thumb is not considered a loss of function, so no value is allowed.

(i) Sensory loss or hypersensitivity in the forearm or arm is not considered a loss of function, therefore no value is allowed.

(j) When there are multiple losses of palmar sensation in a single body part (e.g., hand, finger(s), or thumb), the impairment values are first combined for an overall loss of sensation value for the individual digit or hand. This value is then combined with other impairment values for that digit or hand prior to conversion.

(k) Hypersensitivity is valued using the above loss of sensation tables. Mild hypersensitivity is valued at the equivalent impairment level as less than normal sensation, moderate hypersensitivity the equivalent of protective sensation loss, and severe hypersensitivity the equivalent of a total loss of sensation.

(l) When there is a loss of use or function due to hypersensitivity and decreased two-point discrimination (i.e., sensation loss), both conditions are rated.

(2) When surgery or an injury results in arm length discrepancies involving the injured arm, the following values are given on the affected arm for the length discrepancy:

Discrepancy in inches	Arm impairment
Less than 1 inch	0%
1 inch or more, but less than 2 inches	5%
2 inches or more but less than 3 inches	10%
3 inches or more but less than 4 inches	15%
4 inches or more	20%

(3) Joint instability in the finger(s), thumb, hand, or wrist is rated based on the body part affected:

	Finger			Thumb		Hand	Wrist
	MP	PIP	DIP	MP	IP	CMC	
Mild: Less than 10°	20%	16%	9%	2%	3%	15%	15%
Moderate: 10° to 20°	40%	32%	18%	4%	6%	30%	30%
Severe: Greater than 20°	60%	48%	27%	6%	9%	45%	45%

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(4) Lateral deviation or malalignment of the upper extremity is valued as follows:

(a) Increased lateral deviation at the elbow is determined as follows:

Severity of deviation	Arm impairment
Mild: less than 20°	7%
Moderate: 20° - 30°	14%
Severe: Greater than 30°	21%

(b) Fracture resulting in angulation or malalignment, other than at the elbow, is determined as follows:

Deformity	Impairment
Radius or ulna	10% forearm
Humerus	25% arm

(c) Rotational, lateral, dorsal, or palmar deformity of the thumb receives a value of 10% of the thumb for each type of deformity.

(d) Rotational, lateral, dorsal, or palmar deformity of a finger receives a value of 10% for the finger for each type of deformity.

(5) Surgery on the upper extremity is valued as follows:

(a)	Finger/thumb surgery	Finger impairment
	Arthroplasty	1/2 the lowest ankylosis value for the involved joint
(b)	Forearm/hand surgery	Forearm/hand impairment
	Carpometacarpal arthroplasty	1/2 the lowest ankylosis value for the involved joint
	Carpal bone fusion	5% each (Add values up to 30% maximum)
	Loss of all or part of metacarpal	10%
	Prosthetic carpal bone replacement	5%
	Carpal bone removal, (any portion) without replacement	5% maximum for each carpal bone
	Prosthetic distal ulnar replacement	5%
	Distal ulnar resection, without replacement	10%
(c)	Arm surgery	Arm impairment
	Prosthetic radial head replacement	10%
	Radial head resection, without replacement	15%
	Prosthetic elbow joint replacement	35%
	Humeral head replacement	15%

(6) Dermatological conditions, including burns, which are limited to the arm, forearm, hand, fingers, or thumb are rated based on the body part affected. The percentages indicated in the classes below are applied to the affected body part(s), e.g. a

Class 1 dermatological condition of the thumb is 3% of the thumb, or a Class 1 dermatological condition of the hand is 3% of the hand, or a Class 1 dermatological condition of the arm is 3% of the arm. Contact dermatitis of an upper extremity is rated in this section unless it is an allergic systemic reaction, which is also rated under OAR 436-035-0450. Contact dermatitis for a body part other than the upper or lower extremities is rated under OAR 436-035-0440. Impairments may or may not show signs or symptoms of skin disorder upon examination but are rated under the following classes:

(a) **Class 1:** 3% for the affected body part if treatment results in no more than minimal limitation in the performance of activities of daily living (ADL), although exposure to physical or chemical agents may temporarily increase limitations.

(b) **Class 2:** 15% for the affected body part if intermittent treatments and prescribed examinations are required, and the worker has some limitations in the performance of ADL.

(c) **Class 3:** 38% for the affected body part if regularly prescribed examinations and continuous treatments are required, and the worker has many limitations in the performance of ADL.

(d) **Class 4:** 68% for the affected body part if continuous prescribed treatments are required. The treatment may include periodically having the worker stay home or admitting the worker to a care facility, and the worker has many limitations in the performance of ADL.

(e) **Class 5:** 90% for the affected body part if continuous prescribed treatment is required. The treatment necessitates having the worker stay home or being permanently admitted to a care facility, and the worker has severe limitations in the performance of ADL.

(7) Vascular dysfunction of the upper extremity is valued based on the affected body part, using the following classification table:

(a) **Class 1:** 3% for the affected body part if the worker experiences only transient edema; and on physical examination, the findings are limited to the following: loss of pulses, minimal loss of subcutaneous tissue of fingertips, calcification of arteries as detected by radiographic examination, asymptomatic dilation of arteries or veins (not requiring surgery and not resulting in curtailment of activity); or cold intolerance (e.g., Raynaud's phenomenon) which results in a loss of use or function that occurs with exposure to temperatures below freezing (0° centigrade).

(b) **Class 2:** 15% for the affected body part if the worker experiences intermittent pain with repetitive exertional activity; or there is persistent moderate edema incompletely controlled by elastic supports; or there are signs of vascular damage such as a healed stump of an amputated digit, with evidence of persistent vascular disease, or a healed ulcer; or cold intolerance (e.g., Raynaud's phenomenon) which results in a loss of use or function that occurs on exposure to temperatures below 4° centigrade.

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(c) Class 3: 35% for the affected body part if the worker experiences intermittent pain with moderate upper extremity usage; or there is marked edema incompletely controlled by elastic supports; or there are signs of vascular damage such as a healed amputation of two or more digits, with evidence of persistent vascular disease, or superficial ulceration; or cold intolerance (e.g., Raynaud's phenomenon) which results in a loss of use or function that occurs on exposure to temperatures below 10° centigrade.

(d) Class 4: 63% for the affected body part if the worker experiences intermittent pain upon mild upper extremity usage; or there is marked edema that cannot be controlled by elastic supports; or there are signs of vascular damage such as an amputation at or above the wrist, with evidence of persistent vascular disease, or persistent widespread or deep ulceration involving one extremity; or cold intolerance (e.g., Raynaud's phenomenon) which results in a loss of use or function that occurs on exposure to temperatures below 15° centigrade.

(e) Class 5: 88% for the affected body part if the worker experiences constant and severe pain at rest; or there are signs of vascular damage involving more than one extremity such as amputation at or above the wrist, or amputation of all digits involving more than one extremity with evidence of persistent vascular disease, or persistent widespread deep ulceration involving more than one extremity; or cold intolerance such as Raynaud's phenomenon which results in a loss of use or function that occurs on exposure to temperatures below 20° centigrade.

(f) If partial amputation of the affected body part occurs as a result of vascular disease, the impairment values are rated separately.

(8) Neurological dysfunction resulting in cold intolerance in the upper extremity is valued under the affected body part using the same classifications for cold intolerance due to vascular dysfunction in section (7) of this rule.

(9) Injuries to unilateral spinal nerve roots or brachial plexus with resultant loss of strength in the arm, forearm or hand are rated based on the specific nerve root which supplies (innervates) the weakened muscle(s), as described in the following table and modified under OAR 436-035-0011(7):

(a) Spinal nerve root arm impairment

C-5	30%
C-6	35%
C-7	35%
C-8	45%
T-1	20%

(b) For loss of strength in bilateral extremities, each extremity is rated separately.

(10) When a spinal nerve root or brachial plexus are not injured, valid loss of strength in the arm, forearm or hand is valued as if the peripheral nerve supplying (innervating) the muscle(s) demonstrating the decreased strength was impaired, as described in the following table and as modified under OAR 436-035-0011(7).

Peripheral nerve	Forearm impairment
Median (above mid-forearm below elbow)	69%
Median (below mid-forearm)	44%
Radial (musculospiral) (forearm with sparing of triceps)	50%
Ulnar (above mid-forearm)	44%
Ulnar (below mid-forearm)	31%
	Arm impairment
Radial (upper arm with loss of triceps)	55%
Radial (triceps only)	25%
Musculocutaneous	25%

Example 1: A worker suffers a rupture of the biceps tendon. Upon recovery, the attending physician reports 4/5 strength of the biceps. The biceps is innervated by the musculocutaneous nerve which has a 25% impairment value. 4/5 strength, under OAR 436-035-0011(7), is 20%. Final impairment is determined by multiplying 25% by 20% for a final value of 5% impairment of the arm.

Example 2: A worker suffers a laceration of the median nerve below the mid-forearm. Upon recovery, the attending physician reports 3/5 strength in the forearm. The median nerve below the mid-forearm has a 44% impairment value. 3/5 strength, under OAR 436-035-0011(7), is 50%. Final impairment is determined by multiplying 44% by 50% for a final value of 22% impairment of the forearm.

(a) Loss of strength due to an injury in a single finger or thumb receives a value of zero, unless the strength loss is due to a compensable condition that is proximal to the digit.

(b) Decreased strength due to an amputation receives no rating for weakness in addition to that given for the amputation.

(c) Decreased strength due to a loss in range of motion receives no rating for weakness in addition to that given for the loss of range of motion.

(d) When loss of strength is present in the shoulder, refer to OAR 436-035-0330 for determination of the impairment.

(11) For motor loss in any part of an arm that is due to brain or spinal cord damage, impairment is valued as follows:

(a) Class 1: 14% when the involved extremity can be used for self care, grasping, and holding but has difficulty with digital dexterity.

(b) Class 2: 34% when the involved extremity can be used for self care, grasping and holding objects with difficulty, but has no digital dexterity.

(c) Class 3: 55% when the involved extremity can be used but has difficulty with self care activities.

(d) Class 4: 100% when the involved extremity cannot be used for self care.

(e) When a value is granted under this section, additional impairment values are not allowed for strength loss, chronic condition, or reduced range of motion in the same extremity because they are included in the impairment values shown in this section.

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(f) For bilateral extremity loss, each extremity is rated separately.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0115 Conversion of Upper Extremity Values to Whole Person Values

(1) The tables in this rule are used to convert losses in the upper extremity to a whole person (WP) value for claims with a date of injury on or after January 1, 2005.

(2) The following table is used to convert losses in the thumb and fingers to a whole person (WP) value.

Thumb	WP	Index	WP	Middle	WP
1-9% = 1%		1-18% = 1%		1-21% = 1%	
10-16% = 2%		19-31% = 2%		22-35% = 2%	
17-23% = 3%		32-43% = 3%		36-49% = 3%	
24-29% = 4%		44-56% = 4%		50-64% = 4%	
30-36% = 5%		57-68% = 5%		65-78% = 5%	
37-43% = 6%		69-81% = 6%		79-92% = 6%	
44-49% = 7%		82-93% = 7%		93-100% = 7%	
50-56% = 8%		94-100% = 8%			
57-63% = 9%				Ring	WP
64-69% = 10%				1-49% = 1%	
70-76% = 11%				50-83% = 2%	
77-83% = 12%				84-100% = 3%	
84-89% = 13%				Little	WP
90-96% = 14%				1-74% = 1%	
97-100% = 15%				75-100% = 2%	

(3) The following table is used to convert a loss in a hand/forearm to a whole person (WP) value.

Hand	WP	Hand	WP	Hand	WP
1-3% = 1%		36-37% = 17%		70-71% = 33%	
4-5% = 2%		38-39% = 18%		72-73% = 34%	
6-7% = 3%		40-41% = 19%		74-75% = 35%	
8-9% = 4%		42-43% = 20%		76-77% = 36%	
10-11% = 5%		44-45% = 21%		78-79% = 37%	
12-13% = 6%		46-47% = 22%		80-81% = 38%	
14-15% = 7%		48-49% = 23%		82-84% = 39%	
16-18% = 8%		50-52% = 24%		85-86% = 40%	
19-20% = 9%		53-54% = 25%		87-88% = 41%	
21-22% = 10%		55-56% = 26%		89-90% = 42%	
23-24% = 11%		57-58% = 27%		91-92% = 43%	
25-26% = 12%		59-60% = 28%		93-94% = 44%	
27-28% = 13%		61-62% = 29%		95-96% = 45%	
29-30% = 14%		63-64% = 30%		97-98% = 46%	
31-32% = 15%		65-67% = 31%		99-100% = 47%	
33-35% = 16%		68-69% = 32%			

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(4) The following table is used to convert a loss in the arm to a whole person (WP) value.

Arm	WP	Arm	WP
1-2% = 1%		51-52% = 31%	
3-4% = 2%		53-54% = 32%	
5% = 3%		55% = 33%	
6-7% = 4%		56-57% = 34%	
8-9% = 5%		58-59% = 35%	
10% = 6%		60% = 36%	
11-12% = 7%		61-62% = 37%	
13-14% = 8%		63-64% = 38%	
15% = 9%		65% = 39%	
16-17% = 10%		66-67% = 40%	
18-19% = 11%		68-69% = 41%	
20% = 12%		70% = 42%	
21-22% = 13%		71-72% = 43%	
23-24% = 14%		73-74% = 44%	
25% = 15%		75% = 45%	
26-27% = 16%		76-77% = 46%	
28-29% = 17%		78-79% = 47%	
30% = 18%		80% = 48%	
31-32% = 19%		81-82% = 49%	
33-34% = 20%		83-84% = 50%	
35% = 21%		85% = 51%	
36-37% = 22%		86-87% = 52%	
38-39% = 23%		88-89% = 53%	
40% = 24%		90% = 54%	
41-42% = 25%		91-92% = 55%	
43-44% = 26%		93-94% = 56%	
45% = 27%		95% = 57%	
46-47% = 28%		96-97% = 58%	
48-49% = 29%		98-99% = 59%	
50% = 30%		100% = 60%	

Stat. Auth.: ORS 656.726;

Stats. Implemented: ORS 656;

Hist.: Filed 10/26/04 as WCD Admin. Order 04-063, eff 1/1/05

436-035-0130 Parts of the Lower Extremities

(1) The leg begins with the femoral head and includes the knee joint.

(2) The foot begins just distal to the knee joint and extends just proximal to the metatarsophalangeal joints of the toes.

(3) The toes begin at the metatarsophalangeal joints. Disabilities in the toes are not converted to foot values, regardless of the number of toes involved, unless the foot is also impaired.

Stat. Auth.: ORS 656.726;

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726;

Hist.: Amended 10/26/04 as WCD Admin. Order 04-063, eff 1/1/05

436-035-0140 Amputations in the Lower Extremities

(1) Amputation at or above the knee joint (up to and including the femoral head) is rated at 100% loss of the leg.

(2) Amputation of the foot:

(a) At or above the tibio-talar joint but below the knee joint is rated at 100% loss of the foot.

(b) At the tarsometatarsal joints is rated at 75% loss of the foot.

(c) At the mid-metatarsal area is rated at 50% of the foot.

(d) Loss of all or part of a metatarsal is rated at 10% of the foot.

(3) Amputation of the great toe:

(a) At the interphalangeal joint is rated at 50% loss of the great toe. Between the interphalangeal joint and the tip will be rated in 5% increments, starting with zero for no loss of the tip.

(b) At the metatarsophalangeal joint is rated at 100% loss of the great toe. Between the interphalangeal joint and the metatarsophalangeal joint will be rated in 5% increments, starting with 50% of the great toe for amputation at the interphalangeal joint.

(4) Amputation of the second through fifth toes:

(a) At the distal interphalangeal joint is rated at 50% loss of the toe. Between the distal interphalangeal and the tip will be rated in 5% increments, starting with zero for no loss of the tip.

(b) At the proximal interphalangeal joint is rated at 75% loss of the toe. Between the proximal interphalangeal joint and the distal interphalangeal joint will be rated in 5% increments, starting with 50% of the toe for amputation at the distal interphalangeal joint.

(c) At the metatarsophalangeal joint is rated at 100% loss of the toe. Between the proximal interphalangeal joint and the metatarsophalangeal joint will be rated in 5% increments, starting with 75% of the toe for amputation at the proximal interphalangeal joint.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 10/26/04 as WCD Admin. Order 04-063, eff 1/1/05

436-035-0150 Great Toe

(1) The following ratings are for loss of plantar flexion in the interphalangeal joint of the great toe:

Retained Motion/Percentage of Impairment

0° = 45.0%	10° = 30.0%	20° = 15.0%
1° = 43.5%	11° = 28.5%	21° = 13.5%
2° = 42.0%	12° = 27.0%	22° = 12.0%
3° = 40.5%	13° = 25.5%	23° = 10.5%
4° = 39.0%	14° = 24.0%	24° = 9.0%
5° = 37.5%	15° = 22.5%	25° = 7.5%
6° = 36.0%	16° = 21.0%	26° = 6.0%
7° = 34.5%	17° = 19.5%	27° = 4.5%
8° = 33.0%	18° = 18.0%	28° = 3.0%
9° = 31.5%	19° = 16.5%	29° = 1.5%
		30° = 0.0%

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(2) The following ratings are for plantarflexion ankylosis of the interphalangeal joint of the great toe:

Joint Ankylosed at/Percentage of Impairment

0° = 45%	10° = 55%	20° = 65%
1° = 46%	11° = 56%	21° = 66%
2° = 47%	12° = 57%	22° = 67%
3° = 48%	13° = 58%	23° = 68%
4° = 49%	14° = 59%	24° = 69%
5° = 50%	15° = 60%	25° = 70%
6° = 51%	16° = 61%	26° = 71%
7° = 52%	17° = 62%	27° = 72%
8° = 53%	18° = 63%	28° = 73%
9° = 54%	19° = 64%	29° = 74%
		30° = 75%

(3) The following ratings are for loss of dorsiflexion (extension) in the metatarsophalangeal joint of the great toe:

Retained Motion/Percentage of Impairment

0° = 34.0%	17° = 23.1%	34° = 11.2%
1° = 33.4%	18° = 22.4%	35° = 10.5%
2° = 32.8%	19° = 21.7%	36° = 9.8%
3° = 32.2%	20° = 21.0%	37° = 9.1%
4° = 31.6%	21° = 20.3%	38° = 8.4%
5° = 31.0%	22° = 19.6%	39° = 7.7%
6° = 30.4%	23° = 18.9%	40° = 7.0%
7° = 29.8%	24° = 18.2%	41° = 6.3%
8° = 29.2%	25° = 17.5%	42° = 5.6%
9° = 28.6%	26° = 16.8%	43° = 4.9%
10° = 28.0%	27° = 16.1%	44° = 4.2%
11° = 27.3%	28° = 15.4%	45° = 3.5%
12° = 26.6%	29° = 14.7%	46° = 2.8%
13° = 25.9%	30° = 14.0%	47° = 2.1%
14° = 25.2%	31° = 13.3%	48° = 1.4%
15° = 24.5%	32° = 12.6%	49° = 0.7%
16° = 23.8%	33° = 11.9%	50° = 0.0%

(4) The following ratings are for dorsiflexion (extension) ankylosis of the metatarsophalangeal joint of the great toe:

Joint Ankylosed at/Percentage of Impairment

0° = 55.0%	17° = 58.1%	34° = 79.2%
1° = 54.4%	18° = 59.4%	35° = 80.5%
2° = 53.8%	19° = 60.7%	36° = 81.8%
3° = 53.2%	20° = 62.0%	37° = 83.1%
4° = 52.6%	21° = 63.2%	38° = 84.4%
5° = 52.0%	22° = 64.4%	39° = 85.7%
6° = 51.4%	23° = 65.6%	40° = 87.0%
7° = 50.8%	24° = 66.8%	41° = 88.3%
8° = 50.2%	25° = 67.0%	42° = 89.6%
9° = 49.6%	26° = 69.2%	43° = 90.9%
10° = 49.0%	27° = 70.4%	44° = 92.2%
11° = 50.3%	28° = 71.6%	45° = 93.5%
12° = 51.6%	29° = 72.8%	46° = 94.8%
13° = 52.9%	30° = 74.0%	47° = 96.1%
14° = 54.2%	31° = 75.3%	48° = 97.4%
15° = 55.5%	32° = 76.6%	49° = 98.7%
16° = 56.8%	33° = 77.9%	50° = 100.0%

(5) The following ratings are for loss of plantar flexion in the metatarsophalangeal joint of the great toe:

Retained Motion/Percentage of Impairment

0° = 21.0%	10° = 14.0%	20° = 7.0%
1° = 20.3%	11° = 13.3%	21° = 6.3%
2° = 19.6%	12° = 12.6%	22° = 5.6%
3° = 18.9%	13° = 11.9%	23° = 4.9%
4° = 18.2%	14° = 11.2%	24° = 4.2%
5° = 17.5%	15° = 10.5%	25° = 3.5%
6° = 16.8%	16° = 9.8%	26° = 2.8%
7° = 16.1%	17° = 9.1%	27° = 2.1%
8° = 15.4%	18° = 8.4%	28° = 1.4%
9° = 14.7%	19° = 7.7%	29° = 0.7%
		30° = 0.0%

(6) The following ratings are for plantarflexion ankylosis of the metatarsophalangeal joint of the great toe:

Joint Ankylosed at/Percentage of Impairment

0° = 55.5%	10° = 70.0%	20° = 85.0%
1° = 56.5%	11° = 71.5%	21° = 86.5%
2° = 58.0%	12° = 73.0%	22° = 88.0%
3° = 59.5%	13° = 74.5%	23° = 89.5%
4° = 61.0%	14° = 76.0%	24° = 91.0%
5° = 62.5%	15° = 77.5%	25° = 92.5%
6° = 64.0%	16° = 79.0%	26° = 94.0%
7° = 65.5%	17° = 80.5%	27° = 95.5%
8° = 67.0%	18° = 82.0%	28° = 97.0%
9° = 68.5%	19° = 83.5%	29° = 98.5%
		30° = 100.0%

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 1/14/03 as WCD Admin. Order 03-050, eff. 2/1/03

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436-035-0160 Second Through Fifth Toes

(1) No rating is given for loss of motion in the distal interphalangeal joint of the second through fifth toes (to be referred to as toes), except in the case of ankylosis.

(2) Ankylosis in the distal interphalangeal joint of the toes is rated as follows:

	Toe Impairment
ankylosed in dorsiflexion	45%
ankylosed at 0°	30%
ankylosed in plantarflexion	45%

(3) No rating is given for loss of motion in the proximal interphalangeal joint of the toes, except in the case of ankylosis.

(4) Ankylosis in the proximal interphalangeal joint of the toes is rated as follows:

	Toe Impairment
ankylosed in dorsiflexion	80%
ankylosed at 0°	45%
ankylosed in plantarflexion	80%

(5) The following ratings are for loss of dorsiflexion (extension) in the metatarsophalangeal joints of the toes:

Retained Motion/Percentage of Impairment

0° = 29.0%	14° = 18.2%	28° = 8.4%
1° = 28.2%	15° = 17.5%	29° = 7.7%
2° = 27.4%	16° = 16.8%	30° = 7.0%
3° = 26.6%	17° = 16.1%	31° = 6.3%
4° = 25.8%	18° = 15.4%	32° = 5.6%
5° = 25.0%	19° = 14.7%	33° = 4.9%
6° = 24.2%	20° = 14.0%	34° = 4.2%
7° = 23.4%	21° = 13.3%	35° = 3.5%
8° = 22.6%	22° = 12.6%	36° = 2.8%
9° = 21.8%	23° = 11.9%	37° = 2.1%
10° = 21.0%	24° = 11.2%	38° = 1.4%
11° = 20.3%	25° = 10.5%	39° = 0.7%
12° = 19.6%	26° = 9.8%	40° = 0.0%
13° = 18.9%	27° = 9.1%	

(6) The following ratings are for dorsiflexion (extension) ankylosis in the metatarsophalangeal joints of the toes:

Joint Ankylosed at/Percentage of Impairment

0° = 50.0%	14° = 67.8%	28° = 85.4%
1° = 51.3%	15° = 69.0%	29° = 86.7%
2° = 52.6%	16° = 70.2%	30° = 88.0%
3° = 53.9%	17° = 71.4%	31° = 89.2%
4° = 55.2%	18° = 72.6%	32° = 90.4%
5° = 56.5%	19° = 73.8%	33° = 91.6%
6° = 57.8%	20° = 75.0%	34° = 92.8%
7° = 59.1%	21° = 76.3%	35° = 94.0%
8° = 60.4%	22° = 77.6%	36° = 95.2%
9° = 61.7%	23° = 78.9%	37° = 96.4%
10° = 63.0%	24° = 80.2%	38° = 97.6%
11° = 64.2%	25° = 81.5%	39° = 98.8%
12° = 65.4%	26° = 82.8%	40° = 100.0%
13° = 66.6%	27° = 84.1%	

(7) The following ratings are for loss of (plantar) flexion in the metatarsophalangeal joints of the toes:

Retained Motion/Percentage of Impairment

0° = 21.0%	10° = 14.0%	20° = 7.0%
1° = 20.3%	11° = 13.3%	21° = 6.3%
2° = 19.6%	12° = 12.6%	22° = 5.6%
3° = 18.9%	13° = 11.9%	23° = 4.9%
4° = 18.2%	14° = 11.2%	24° = 4.2%
5° = 17.5%	15° = 10.5%	25° = 3.5%
6° = 16.8%	16° = 9.8%	26° = 2.8%
7° = 16.1%	17° = 9.1%	27° = 2.1%
8° = 15.4%	18° = 8.4%	28° = 1.4%
9° = 14.7%	19° = 7.7%	29° = 0.7%
		30° = 0.0%

(8) Plantarflexion ankylosis in the metatarsophalangeal joints of the toes is rated as follows:

Joint Ankylosed at/Percentage of Impairment

0° = 50.0%	10° = 67.0%	20° = 83.0%
1° = 51.7%	11° = 68.6%	21° = 84.7%
2° = 53.4%	12° = 70.2%	22° = 86.4%
3° = 55.1%	13° = 71.8%	23° = 88.1%
4° = 56.8%	14° = 73.4%	24° = 89.8%
5° = 58.5%	15° = 75.0%	25° = 91.5%
6° = 60.2%	16° = 76.6%	26° = 93.2%
7° = 61.9%	17° = 78.2%	27° = 94.9%
8° = 63.6%	18° = 79.8%	28° = 96.6%
9° = 65.3%	19° = 81.4%	29° = 98.3%
		30° = 100.0%

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 10/26/04 as WCD Admin. Order 04-063, eff 1/1/05

436-035-0180 Conversion of Toe Values to Foot Value

(1) If the only findings are in the toes, it is not possible to convert the toe findings to a loss in the foot unless there are

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impairment findings in the foot. Each toe must be converted to the foot separately. After converting to the foot, each converted value is added.

(2) If there are impairment findings in the foot and impairment findings in the great toe, the following table is used to convert losses in the great toe to losses in the foot:

Great Toe	Foot	Great Toe	Foot
1- 7% = 1%		51-57% = 8%	
8-14% = 2%		58-64% = 9%	
15-21% = 3%		65-71% = 10%	
22-28% = 4%		72-78% = 11%	
29-35% = 5%		79-85% = 12%	
36-42% = 6%		86-92% = 13%	
43-50% = 7%		93-100% = 14%	

(3) If there are impairment findings in the foot and impairment findings in the second through the fifth toes, the following table is used to convert losses in the toes to losses in the foot:

Toe	Foot
1-33% = 1%	
34-67% = 2%	
68-100% = 3%	

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 1/8/97 as WCD Admin. Order 96-072, eff. 2/15/97

436-035-0190 Foot

(1) Ankylosis at the tarsometatarsal joints receives a rating of 10% of the foot for each of the tarsometatarsal joints ankylosed.

(2) The following ratings are for loss of subtalar inversion in the foot:

Retained Motion/Percentage of Impairment

0° = 5.0%	10° = 4.0%	20° = 2.0%
1° = 4.9%	11° = 3.8%	21° = 1.8%
2° = 4.8%	12° = 3.6%	22° = 1.6%
3° = 4.7%	13° = 3.4%	23° = 1.4%
4° = 4.6%	14° = 3.2%	24° = 1.2%
5° = 4.5%	15° = 3.0%	25° = 1.0%
6° = 4.4%	16° = 2.8%	26° = 0.8%
7° = 4.3%	17° = 2.6%	27° = 0.6%
8° = 4.2%	18° = 2.4%	28° = 0.4%
9° = 4.1%	19° = 2.2%	29° = 0.2%
		30° = 0.0%

(3) The following ratings are for subtalar inversion (varus) ankylosis in the foot:

Joint Ankylosed at/Percentage of Impairment

0° = 10.0%	10° = 43.0%	20° = 57.0%
1° = 13.3%	11° = 44.4%	21° = 58.3%
2° = 16.6%	12° = 45.8%	22° = 59.6%
3° = 19.9%	13° = 47.2%	23° = 60.9%
4° = 23.2%	14° = 48.6%	24° = 62.2%
5° = 26.5%	15° = 50.0%	25° = 63.5%
6° = 29.8%	16° = 51.4%	26° = 64.8%
7° = 33.1%	17° = 52.8%	27° = 66.1%
8° = 36.4%	18° = 54.2%	28° = 67.4%
9° = 39.7%	19° = 55.6%	29° = 68.7%
		30° = 70.0%

(4) The following ratings are for loss of subtalar eversion in the foot:

Retained Motion/Percentage of Impairment

0° = 4.0%	7° = 2.6%	14° = 1.2%
1° = 3.8%	8° = 2.4%	15° = 1.0%
2° = 3.6%	9° = 2.2%	16° = 0.8%
3° = 3.4%	10° = 2.0%	17° = 0.6%
4° = 3.2%	11° = 1.8%	18° = 0.4%
5° = 3.0%	12° = 1.6%	19° = 0.2%
6° = 2.8%	13° = 1.4%	20° = 0.0%

(5) The following ratings are for subtalar eversion (valgus) ankylosis in the foot:

Joint Ankylosed at/Percentage of Impairment

0° = 10%	7° = 38%	14° = 54%
1° = 14%	8° = 42%	15° = 55%
2° = 18%	9° = 46%	16° = 56%
3° = 22%	10° = 50%	17° = 57%
4° = 26%	11° = 51%	18° = 58%
5° = 30%	12° = 52%	19° = 59%
6° = 34%	13° = 53%	20° = 60%

(6) The following ratings are for loss of dorsiflexion (extension) in the ankle joint:

Retained Motion/Percentage of Impairment

0° = 7.0%	7° = 4.9%	14° = 2.4%
1° = 6.7%	8° = 4.6%	15° = 2.0%
2° = 6.4%	9° = 4.3%	16° = 1.6%
3° = 6.1%	10° = 4.0%	17° = 1.2%
4° = 5.8%	11° = 3.6%	18° = 0.8%
5° = 5.5%	12° = 3.2%	19° = 0.4%
6° = 5.2%	13° = 2.8%	20° = 0.0%

(7) The following ratings are for dorsiflexion (extension) ankylosis in the ankle joint:

Joint Ankylosed at/Percentage of Impairment

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0° = 30%	7° = 44%	14° = 58%
1° = 32%	8° = 46%	15° = 60%
2° = 34%	9° = 48%	16° = 62%
3° = 36%	10° = 50%	17° = 64%
4° = 38%	11° = 52%	18° = 66%
5° = 40%	12° = 54%	19° = 68%
6° = 42%	13° = 56%	20° = 70%

(8) The following ratings are for loss of plantarflexion in the ankle joint:

Retained Motion/Percentage of Impairment

0° = 14.0%	14° = 9.4%	28° = 4.6%
1° = 13.7%	15° = 9.0%	29° = 4.3%
2° = 13.4%	16° = 8.6%	30° = 4.0%
3° = 13.1%	17° = 8.2%	31° = 3.6%
4° = 12.8%	18° = 7.8%	32° = 3.2%
5° = 12.5%	19° = 7.4%	33° = 2.8%
6° = 12.2%	20° = 7.0%	34° = 2.4%
7° = 11.9%	21° = 6.7%	35° = 2.0%
8° = 11.6%	22° = 6.4%	36° = 1.6%
9° = 11.3%	23° = 6.1%	37° = 1.2%
10° = 11.0%	24° = 5.8%	38° = 0.8%
11° = 10.6%	25° = 5.5%	39° = 0.4%
12° = 10.2%	26° = 5.2%	40° = 0.0%
13° = 9.8%	27° = 4.9%	

(9) The following ratings are for plantarflexion ankylosis in the ankle joint:

Joint Ankylosed at/Percentage of Impairment

0° = 30%	14° = 44%	28° = 58%
1° = 31%	15° = 45%	29° = 59%
2° = 32%	16° = 46%	30° = 60%
3° = 33%	17° = 47%	31° = 61%
4° = 34%	18° = 48%	32° = 62%
5° = 35%	19° = 49%	33° = 63%
6° = 36%	20° = 50%	34° = 64%
7° = 37%	21° = 51%	35° = 65%
8° = 38%	22° = 52%	36° = 66%
9° = 39%	23° = 53%	37° = 67%
10° = 40%	24° = 54%	38° = 68%
11° = 41%	25° = 55%	39° = 69%
12° = 42%	26° = 56%	40° = 70%
13° = 43%	27° = 57%	

(10) The following applies when determining impairment for loss of motion or ankylosis in the ankle or subtalar joint:

(a) If there is loss of motion only (no ankylosis in either joint) in the subtalar joint or the ankle joint, the following applies:

(A) the values for loss of motion in the subtalar joint are added;

(B) the values for loss of motion in the ankle joint are added;

(C) the value for loss of motion in the subtalar joint is added to the value for loss of motion in the ankle joint.

(b) If there is ankylosis in the ankle or subtalar joint, the following applies:

(A) When there is ankylosis in one joint only with no loss of motion or ankylosis in the other joint, that ankylosis value is granted.

(B) When there is loss of motion in one joint and ankylosis in the other joint, add the ankylosis value to the value for loss of motion in the non-ankylosed joint.

(C) When the ankle joint is ankylosed in plantar flexion and dorsiflexion, use only the largest ankylosis value for rating the loss or only one of the values if they are identical. Under OAR 436-035-0011(10), this ankylosis value is granted in lieu of all other range of motion or ankylosis values for the ankle joint.

(D) When the subtalar joint is ankylosed in inversion and eversion, use only the largest ankylosis value for rating the loss or only one of the values if they are identical. Under OAR 436-035-0011(10), this ankylosis value is granted in lieu of all other range of motion or ankylosis values for the subtalar joint.

(E) When both joints are ankylosed, add the ankle joint value to the subtalar joint value.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 5/5/10 as WCD Admin. Order 10-051, eff. 6/1/10

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436-035-0210 Conversion of Foot Value to Leg Value

(1) The following ratings are for converting losses in the foot to losses in the leg:

Impairment of Foot Leg	Impairment of Foot Leg	Impairment of Foot Leg
1% = 1%	34% = 31%	68% = 61%
2% = 2%	35-36% = 32%	69% = 62%
3% = 3%	37% = 33%	70% = 63%
4% = 4%	38% = 34%	71% = 64%
5-6% = 5%	39% = 35%	72% = 65%
7% = 6%	40% = 36%	73% = 66%
8% = 7%	41% = 37%	74% = 67%
9% = 8%	42% = 38%	75-76% = 68%
10% = 9%	43% = 39%	77% = 69%
11% = 10%	44% = 40%	78% = 70%
12% = 11%	45-46% = 41%	79% = 71%
13% = 12%	47% = 42%	80% = 72%
14% = 13%	48% = 43%	81% = 73%
15-16% = 14%	49% = 44%	82% = 74%
17% = 15%	50% = 45%	83% = 75%
18% = 16%	51% = 46%	84% = 76%
19% = 17%	52% = 47%	85-86% = 77%
20% = 18%	53% = 48%	87% = 78%
21% = 19%	54% = 49%	88% = 79%
22% = 20%	55-56% = 50%	89% = 80%
23% = 21%	57% = 51%	90% = 81%
24% = 22%	58% = 52%	91% = 82%
25-26% = 23%	59% = 53%	92% = 83%
27% = 24%	60% = 54%	93% = 84%
28% = 25%	61% = 55%	94% = 85%
29% = 26%	62% = 56%	95-96% = 86%
30% = 27%	63% = 57%	97% = 87%
31% = 28%	64% = 58%	98% = 88%
32% = 29%	65-66% = 59%	99% = 89%
33% = 30%	67% = 60%	100% = 90%

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 3/26/91 as WCD Admin. Order 2-1991, eff. 4/1/91

436-035-0220 Leg

(1) The following ratings are for loss of flexion in the knee (150° describes the knee in full flexion):

Retained Motion/Percentage of Impairment

0° = 53.0%	38° = 39.6%	76° = 26.2%	114° = 12.8%
1° = 52.6%	39° = 39.3%	77° = 25.9%	115° = 12.5%
2° = 52.2%	40° = 39.0%	78° = 25.6%	116° = 12.2%
3° = 51.8%	41° = 38.6%	79° = 25.3%	117° = 11.9%
4° = 51.4%	42° = 38.2%	80° = 25.0%	118° = 11.6%
5° = 51.0%	43° = 37.8%	81° = 24.6%	119° = 11.3%
6° = 50.6%	44° = 37.4%	82° = 24.2%	120° = 11.0%
7° = 50.2%	45° = 37.0%	83° = 23.8%	121° = 10.6%
8° = 49.8%	46° = 36.6%	84° = 23.4%	122° = 10.2%
9° = 49.4%	47° = 36.2%	85° = 23.0%	123° = 9.8%
10° = 49.0%	48° = 35.8%	86° = 22.6%	124° = 9.4%
11° = 48.7%	49° = 35.4%	87° = 22.2%	125° = 9.0%
12° = 48.4%	50° = 35.0%	88° = 21.8%	126° = 8.6%
13° = 48.1%	51° = 34.7%	89° = 21.4%	127° = 8.2%
14° = 47.8%	52° = 34.4%	90° = 21.0%	128° = 7.8%
15° = 47.5%	53° = 34.1%	91° = 20.7%	129° = 7.4%
16° = 47.2%	54° = 33.8%	92° = 20.4%	130° = 7.0%
17° = 46.9%	55° = 33.5%	93° = 20.1%	131° = 6.7%
18° = 46.6%	56° = 33.2%	94° = 19.8%	132° = 6.4%
19° = 46.3%	57° = 32.9%	95° = 19.5%	133° = 6.1%
20° = 46.0%	58° = 32.6%	96° = 19.2%	134° = 5.8%
21° = 45.6%	59° = 32.3%	97° = 18.9%	135° = 5.5%
22° = 45.2%	60° = 32.0%	98° = 18.6%	136° = 5.2%
23° = 44.8%	61° = 31.6%	99° = 18.3%	137° = 4.9%
24° = 44.4%	62° = 31.2%	100° = 18.0%	138° = 4.6%
25° = 44.0%	63° = 30.8%	101° = 17.6%	139° = 4.3%
26° = 43.6%	64° = 30.4%	102° = 17.2%	140° = 4.0%
27° = 43.2%	65° = 30.0%	103° = 16.8%	141° = 3.6%
28° = 42.8%	66° = 29.6%	104° = 16.4%	142° = 3.2%
29° = 42.4%	67° = 29.2%	105° = 16.0%	143° = 2.8%
30° = 42.0%	68° = 28.8%	106° = 15.6%	144° = 2.4%
31° = 41.7%	69° = 28.4%	107° = 15.2%	145° = 2.0%
32° = 41.4%	70° = 28.0%	108° = 14.8%	146° = 1.6%
33° = 41.1%	71° = 27.7%	109° = 14.4%	147° = 1.2%
34° = 40.8%	72° = 27.4%	110° = 14.0%	148° = 0.8%
35° = 40.5%	73° = 27.1%	111° = 13.7%	149° = 0.4%
36° = 40.2%	74° = 26.8%	112° = 13.4%	150° = 0.0%
37° = 39.9%	75° = 26.5%	113° = 13.1%	

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(2) The following ratings are for loss of extension in the knee (0° describes the knee in full extension):

Retained Motion/Percentage of Impairment

0° = 0.0%	17° = 5.2%	34° = 21.0%
1° = 0.1%	18° = 5.8%	35° = 22.0%
2° = 0.2%	19° = 6.4%	36° = 23.0%
3° = 0.3%	20° = 7.0%	37° = 24.0%
4° = 0.4%	21° = 8.0%	38° = 25.0%
5° = 0.5%	22° = 9.0%	39° = 26.0%
6° = 0.6%	23° = 10.0%	40° = 27.0%
7° = 0.7%	24° = 11.0%	41° = 33.3%
8° = 0.8%	25° = 12.0%	42° = 39.6%
9° = 0.9%	26° = 13.0%	43° = 45.9%
10° = 1.0%	27° = 14.0%	44° = 52.2%
11° = 1.6%	28° = 15.0%	45° = 58.5%
12° = 2.2%	29° = 16.0%	46° = 64.8%
13° = 2.8%	30° = 17.0%	47° = 71.1%
14° = 3.4%	31° = 18.0%	48° = 77.4%
15° = 4.0%	32° = 19.0%	49° = 83.7%
16° = 4.6%	33° = 20.0%	50 - 150° = 90.0%

(3) Ankylosis of the knee in flexion or extension is rated as follows:

Joint Ankylosed at/Percentage of Impairment

0° = 53.0%	17° = 57%	34° = 74%
1° = 52.7%	18° = 58%	35° = 75%
2° = 52.4%	19° = 59%	36° = 76%
3° = 52.1%	20° = 60%	37° = 77%
4° = 51.8%	21° = 61%	38° = 78%
5° = 51.5%	22° = 62%	39° = 79%
6° = 51.2%	23° = 63%	40° = 80%
7° = 50.9%	24° = 64%	41° = 81%
8° = 50.6%	25° = 65%	42° = 82%
9° = 50.3%	26° = 66%	43° = 83%
10° = 50.0%	27° = 67%	44° = 84%
11° = 51.0%	28° = 68%	45° = 85%
12° = 52.0%	29° = 69%	46° = 86%
13° = 53%	30° = 70%	47° = 87%
14° = 54%	31° = 71%	48° = 88%
15° = 55%	32° = 72%	49° = 89%
16° = 56%	33° = 73%	50 - 150° = 90%

(4) The determination of loss of range of motion in the hip is valued in this section when there is no pelvic bone involvement. Loss associated with pelvic bone involvement is determined under OAR 436-035-0340.

(5) The following ratings are for loss of forward flexion in the hip:

Retained Motion/Percentage of Impairment

0° = 18.0%	34° = 11.6%	68° = 5.4%
1° = 17.8%	35° = 11.5%	69° = 5.2%
2° = 17.6%	36° = 11.4%	70° = 5.0%
3° = 17.4%	37° = 11.3%	71° = 4.9%
4° = 17.2%	38° = 11.2%	72° = 4.8%
5° = 17.0%	39° = 11.1%	73° = 4.7%
6° = 16.8%	40° = 11.0%	74° = 4.6%
7° = 16.6%	41° = 10.8%	75° = 4.5%
8° = 16.4%	42° = 10.6%	76° = 4.4%
9° = 16.2%	43° = 10.4%	77° = 4.3%
10° = 16.0%	44° = 10.2%	78° = 4.2%
11° = 15.8%	45° = 10.0%	79° = 4.1%
12° = 15.6%	46° = 9.8%	80° = 4.0%
13° = 15.4%	47° = 9.6%	81° = 3.8%
14° = 15.2%	48° = 9.4%	82° = 3.6%
15° = 15.0%	49° = 9.2%	83° = 3.4%
16° = 14.8%	50° = 9.0%	84° = 3.2%
17° = 14.6%	51° = 8.8%	85° = 3.0%
18° = 14.4%	52° = 8.6%	86° = 2.8%
19° = 14.2%	53° = 8.4%	87° = 2.6%
20° = 14.0%	54° = 8.2%	88° = 2.4%
21° = 13.8%	55° = 8.0%	89° = 2.2%
22° = 13.6%	56° = 7.8%	90° = 2.0%
23° = 13.4%	57° = 7.6%	91° = 1.8%
24° = 13.2%	58° = 7.4%	92° = 1.6%
25° = 13.0%	59° = 7.2%	93° = 1.4%
26° = 12.8%	60° = 7.0%	94° = 1.2%
27° = 12.6%	61° = 6.8%	95° = 1.0%
28° = 12.4%	62° = 6.6%	96° = 0.8%
29° = 12.2%	63° = 6.4%	97° = 0.6%
30° = 12.0%	64° = 6.2%	98° = 0.4%
31° = 11.9%	65° = 6.0%	99° = 0.2%
32° = 11.8%	66° = 5.8%	100° = 0.0%
33° = 11.7%	67° = 5.6%	

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(6) The following ratings are for loss of backward extension in the hip joint:

Retained Motion/Percentage of Impairment

0° = 5.0%	10° = 4.0%	20° = 2.0%
1° = 4.9%	11° = 3.8%	21° = 1.8%
2° = 4.8%	12° = 3.6%	22° = 1.6%
3° = 4.7%	13° = 3.4%	23° = 1.4%
4° = 4.6%	14° = 3.2%	24° = 1.2%
5° = 4.5%	15° = 3.0%	25° = 1.0%
6° = 4.4%	16° = 2.8%	26° = 0.8%
7° = 4.3%	17° = 2.6%	27° = 0.6%
8° = 4.2%	18° = 2.4%	28° = 0.4%
9° = 4.1%	19° = 2.2%	29° = 0.2%
		30° = 0.0%

(7) The following ratings are for loss of abduction in the hip joint:

Retained Motion/Percentage of Impairment

0° = 16.0%	14° = 10.4%	28° = 4.8%
1° = 15.6%	15° = 10.0%	29° = 4.4%
2° = 15.2%	16° = 9.6%	30° = 4.0%
3° = 14.8%	17° = 9.2%	31° = 3.6%
4° = 14.4%	18° = 8.8%	32° = 3.2%
5° = 14.0%	19° = 8.4%	33° = 2.8%
6° = 13.6%	20° = 8.0%	34° = 2.4%
7° = 13.2%	21° = 7.6%	35° = 2.0%
8° = 12.8%	22° = 7.2%	36° = 1.6%
9° = 12.4%	23° = 6.8%	37° = 1.2%
10° = 12.0%	24° = 6.4%	38° = 0.8%
11° = 11.6%	25° = 6.0%	39° = 0.4%
12° = 11.2%	26° = 5.6%	40° = 0.0%
13° = 10.8%	27° = 5.2%	

(8) The following ratings are for loss of adduction in the hip joint:

Retained Motion/Percentage of Impairment

0° = 8.0%	7° = 5.2%	14° = 2.4%
1° = 7.6%	8° = 4.8%	15° = 2.0%
2° = 7.2%	9° = 4.4%	16° = 1.6%
3° = 6.8%	10° = 4.0%	17° = 1.2%
4° = 6.4%	11° = 3.6%	18° = 0.8%
5° = 6.0%	12° = 3.2%	19° = 0.4%
6° = 5.6%	13° = 2.8%	20° = 0.0%

(9) The following ratings are for loss of internal rotation in the hip joint:

Retained Motion/Percentage of Impairment

0° = 10.0%	14° = 6.8%	28° = 3.4%
1° = 9.8%	15° = 6.5%	29° = 3.2%
2° = 9.6%	16° = 6.2%	30° = 3.0%
3° = 9.4%	17° = 5.9%	31° = 2.7%
4° = 9.2%	18° = 5.6%	32° = 2.4%
5° = 9.0%	19° = 5.3%	33° = 2.1%
6° = 8.8%	20° = 5.0%	34° = 1.8%
7° = 8.6%	21° = 4.8%	35° = 1.5%
8° = 8.4%	22° = 4.6%	36° = 1.2%
9° = 8.2%	23° = 4.4%	37° = 0.9%
10° = 8.0%	24° = 4.2%	38° = 0.6%
11° = 7.7%	25° = 4.0%	39° = 0.3%
12° = 7.4%	26° = 3.8%	40° = 0.0%
13° = 7.1%	27° = 3.6%	

(10) The following ratings are for loss of external rotation in the hip joint:

Retained Motion/Percentage of Impairment

0° = 13.0%	17° = 8.6%	34° = 4.2%
1° = 12.7%	18° = 8.4%	35° = 4.0%
2° = 12.4%	19° = 8.2%	36° = 3.8%
3° = 12.1%	20° = 8.0%	37° = 3.6%
4° = 11.8%	21° = 7.7%	38° = 3.4%
5° = 11.5%	22° = 7.4%	39° = 3.2%
6° = 11.2%	23° = 7.1%	40° = 3.0%
7° = 10.9%	24° = 6.8%	41° = 2.7%
8° = 10.6%	25° = 6.5%	42° = 2.4%
9° = 10.3%	26° = 6.2%	43° = 2.1%
10° = 10.0%	27° = 5.9%	44° = 1.8%
11° = 9.8%	28° = 5.6%	45° = 1.5%
12° = 9.6%	29° = 5.3%	46° = 1.2%
13° = 9.4%	30° = 5.0%	47° = 0.9%
14° = 9.2%	31° = 4.8%	48° = 0.6%
15° = 9.0%	32° = 4.6%	49° = 0.3%
16° = 8.8%	33° = 4.4%	50° = 0.0%

(11) Ankylosis in the hip joint is rated under OAR 436-035-0340.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 10/26/04 as WCD Admin. Order 04-063, eff 1/1/05

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436-035-0230 Other Lower Extremity Findings

(1) Loss of sensation or hypersensitivity in the leg is not considered disabling except for the plantar surface of the foot and toes, including the great toe, where it is rated as follows:

	Toe (in any toe)	Foot
partial loss of sensation or hypersensitivity	5%	5%
total loss of sensation or hypersensitivity	10%	10%

(b) Partial is part of the toe or foot. Total means the entire toe or foot.

(c) Loss of sensation or hypersensitivity in the toes in addition to loss of sensation or hypersensitivity in the foot is rated for the foot only. No additional value is allowed for loss of sensation or hypersensitivity in the toes.

(d) When there are hypersensitivity and sensation loss, both conditions are rated.

(2) The following ratings are for length discrepancies of the injured leg. However, loss of length due to flexion/extension deformities is excluded. The rating is the same whether the length change is a result of an injury to the foot or to the upper leg:

Discrepancy in inches	Leg
1/4 to 1/2 inch	5%
More than 1/2 inch up to and including 1 inch	10%
More than 1 inch up to and including 1-1/2 inches	15%
More than 1-1/2 inches	20%

(3) Valid instability in the ankle or knee substantiated by clinical findings is valued based on the ligament demonstrating the laxity, as described in the table below. The instability value is given even if the ligament itself has not been injured.

Ligament	Mild		Moderate		Severe	
	Ankle	Leg	Ankle	Leg	Ankle	Leg
Collateral (medial)	6%	10%	11%	15%	17%	20%
Collateral (lateral)	9%	10%	18%	15%	28%	20%
Anterior cruciate		5%		10%		15%
Posterior cruciate		5%		10%		15%

(a) For ankle joint instability to be rated as severe there must be a complete disruption of two or more ligaments. Following are examples of ankle ligaments that may contribute to joint instability:

(A) The lateral collateral ligaments including the anterior talofibular, calcaneofibular, talocalcaneal, posterior talocalcaneal, and the posterior talofibular.

(B) The medial collateral ligaments, or deltoid ligament, including the tibionavicular, calcaneotibial, anterior talotibial, and the posterior talotibial.

(b) For knee joint instability the severity of joint opening is mild at a grade 1 or 1+ (1-5mm), moderate at a grade 2 or 2+ (6-10mm), and severe at a grade 3 or 3+ (>10mm).

(c) Ankle joint instability with additional anterior or posterior instability receives an additional 10%.

(d) When there is a prosthetic knee replacement, instability of the knee is not rated unless the severity of the instability is equivalent to Grade 2 or greater.

(e) Rotary instability in the knee is included in the impairment value(s) of this section.

(f) Multiple instability values in a single joint are combined.

(4) When injury in the ankle or knee/leg results in angulation or malalignment, impairment values are determined under the following:

(a) Varus deformity greater than 15° of the knee/leg is rated at 10% of the leg and of the ankle is rated at 10% of the foot.

(b) Valgus deformity greater than 20° of the knee/leg is rated at 10% of the leg and of the ankle is rated at 10% of the foot.

(c) Tibial shaft fracture resulting in angulation or malalignment (rotational deformity) affects the function of the entire leg and is rated as follows:

Severity Leg impairment

Mild: 10°– 14° 17%

Moderate: 15°– 19° 26%

Severe: 20°+ 26% plus 1% for each additional degree, to 43% maximum

(d) Injury resulting in a rocker bottom deformity of the foot is valued at 14%.

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(5) The following values are for surgery of the toes, foot, or leg:

(a)	In the great toe:	Toe impairment
	interphalangeal joint arthroplasty or resection	20%
	metatarsophalangeal joint arthroplasty or resection	30%
(b)	In the second through fifth toes:	Toe impairment
	distal interphalangeal joint arthroplasty or resection	15%
	proximal interphalangeal joint arthroplasty or resection	25%
	metatarsophalangeal joint arthroplasty or resection	25%
(c)	Foot surgery	Foot/ankle impairment
	Resection of any part of a metatarsal	10%
	Ankylosed tarsometatarsal joint	10%
	Prosthetic ankle replacement	25%
(d)	Leg surgery	Leg impairment
	Less than complete loss of one meniscus (no additional value is allowed for multiple partial resections of a single meniscus)	5%
	Complete loss of one meniscus	10%
	Complete loss of one meniscus with less than complete loss of the other	15%
	Complete loss of both menisci	25%
	Each 1/4 of patella removed	5%
	Prosthetic femoral head replacement	15%
	Total or partial prosthetic knee replacement (no additional value is allowed for multiple, partial or total, replacements).	20%

(e) When rating a prosthetic knee replacement, a separate value for meniscectomy(s) or patellectomy for the same knee is not granted.

(f) A meniscectomy is rated as a complete loss unless the record indicates that more than the rim of the meniscus remains.

(6) Dermatological conditions including burns which are limited to the leg, foot, or toes are rated based on the body part affected. The percentages indicated in the classes below are applied to the affected body part(s), e.g., a Class 1 dermatological condition of the foot is 3% of the foot, or a Class 1 dermatological condition of the leg is 3% of the leg. Contact dermatitis is determined under this section unless it is caused by an allergic systemic reaction which is also determined under OAR 436-035-0450. Contact dermatitis for a body part other than the upper or lower extremities is rated

under OAR 436-035-0440. Impairments may or may not show signs or symptoms of skin disorder upon examination but are rated according to the following classes:

(a) **Class 1:** 3% for the leg, foot, or toe if treatment results in no more than minimal limitations in the performance of the activities of daily living (ADL), although exposure to physical or chemical agents may temporarily increase limitations.

(b) **Class 2:** 15% for the leg, foot, or toe if intermittent treatments and prescribed examinations are required, and the worker has some limitations in the performance of ADL.

(c) **Class 3:** 38% for the leg, foot, or toe if regularly prescribed examinations and continuous treatments are required, and the worker has many limitations in the performance of ADL.

(d) **Class 4:** 68% for the leg, foot, or toe if continuous prescribed treatments are required. The treatment may include periodically having the worker stay home or admitting the worker to a care facility, and the worker has many limitations in the performance of ADL.

(e) **Class 5:** 90% for the leg, foot, or toe if continuous prescribed treatment is required. The treatment necessitates having the worker stay home or permanently admitting the worker to a care facility, and the worker has severe limitations in the performance of ADL.

(f) Full thickness skin loss of the heel is valued at 10% of the foot, even when the area is successfully covered with an appropriate skin graft.

(7) The following ratings are for vascular dysfunction of the leg. The impairment values are determined according to the following classifications:

(a) **Class 1:** 3% when any of the following exist:

(A) Loss of pulses in the foot.

(B) Minimal loss of subcutaneous tissue.

(C) Calcification of the arteries (as revealed by x-ray).

(D) Transient edema.

(b) **Class 2:** 15% when any of the following exist:

(A) Limping due to intermittent claudication that occurs when walking at least 100 yards.

(B) Vascular damage, as evidenced by a healed painless stump of a single amputated toe, with evidence of chronic vascular dysfunction or a healed ulcer.

(C) Persistent moderate edema which is only partially controlled by support hose.

(c) **Class 3:** 35% when any of the following exist:

(A) Limping due to intermittent claudication when walking as little as 25 yards and no more than 100 yards.

(B) Vascular damage, as evidenced by healed amputation stumps of two or more toes on one foot, with evidence of chronic vascular dysfunction or persistent superficial ulcers on one leg.

(C) Obvious severe edema which is only partially controlled by support hose.

(d) **Class 4:** 63% when any of the following exist:

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(A) Limping due to intermittent claudication after walking less than 25 yards.

(B) Intermittent pain in the legs due to intermittent claudication when at rest.

(C) Vascular damage, as evidenced by amputation at or above the ankle on one leg, or amputation of two or more toes on both feet, with evidence of chronic vascular dysfunction or widespread or deep ulcers on one leg.

(D) Obvious severe edema which cannot be controlled with support hose.

(e) **Class 5:** 88% when either of the following exists:

(A) Constant severe pain due to claudication at rest.

(B) Vascular damage, as evidenced by amputations at or above the ankles of both legs, or amputation of all toes on both feet, with evidence of persistent vascular dysfunction or of persistent, widespread, or deep ulcerations on both legs.

(f) If partial amputation of the lower extremity occurs as a result of vascular dysfunction, the impairment values are rated separately. The amputation value is then combined with the impairment value for the vascular dysfunction.

(8) Injuries to unilateral spinal nerve roots with resultant loss of strength in the leg or foot are rated based on the specific nerve root supplying (innervating) the weakened muscle(s), as described in the following table and modified under OAR 436-035-0011(7).

(a)	Spinal nerve root	Leg impairment
	L-2	20%
	L-3	20%
	L-4	34%
	L-5	37%
	S-1	20%

(b) Loss of strength in bilateral extremities results in each extremity being rated separately.

(9) When a spinal nerve root or lumbosacral plexus are not injured, valid loss of strength in the leg or foot is valued as if the peripheral nerve supplying (innervating) the muscle(s) demonstrating the decreased strength was impaired, as described in the following table and as modified under OAR 436-035-0011(7).

		Foot impairment
Common peroneal		39%
	deep (above mid-shin)	28%
	deep (below mid-shin)	6%
	superficial	11%
Tibial nerve		
	posterior tibial (mid-calf & knee)	28%
	below mid-calf	17%
	lateral plantar branch	6%
	medial plantar branch	6%
Peripheral nerve		Leg impairment
	Femoral (Below the iliacus nerve)	30%
	Nerves to obturator internus & piriformis	10%
	Nerves to quadratus femoris muscle/nerve to superior gemellus muscle/obturator	10%
	Superior gluteal	20%
	Inferior gluteal	25%
	Sciatic (above hamstring innervation)	75%
	Sciatic (hamstring loss only)	40%
	Tibial nerve (medial popliteal or internal popliteal above knee)	35%

Example 1: A worker suffers a knee injury requiring surgery. Upon recovery, the attending physician reports 4/5 strength of the quadriceps femoris. The quadriceps femoris is innervated by the femoral nerve which has a 30% impairment value. 4/5 strength, under OAR 436-035-0011(7), is 20%. Final impairment is determined by multiplying 30% by 20% for a final value of 6% impairment of the leg.

Example 2: A worker suffers a laceration of the deep branch of the common peroneal nerve above mid-shin. Upon recovery, the attending physician reports 3/5 strength of the calf. The deep common peroneal above mid-shin has a 28% impairment value. Under OAR 436-035-0011(7), 3/5 strength is 50%. Impairment is determined by multiplying 28% by 50% for a final value of 14% impairment of the foot.

(a) Loss of strength due to an injury in a single toe receives a value of zero, unless the strength loss is due to a compensable condition that is proximal to the digit.

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(b) Decreased strength due to an amputation receives no rating for weakness in addition to that given for the amputation.

(c) Decreased strength due to a loss in range of motion receives no rating for weakness in addition to that given for the loss of range of motion.

(10) For motor loss to any part of a leg which is due to brain or spinal cord damage, impairment is valued as follows:

(a) **Class 1:** 23% when the worker can rise to a standing position and can walk but has difficulty with elevations, grades, steps, and distances.

(b) **Class 2:** 48% when the worker can rise to a standing position and can walk with difficulty but is limited to level surfaces. There is variability as to the distance the worker can walk.

(c) **Class 3:** 76% when the worker can rise to a standing position and can maintain it with difficulty but cannot walk without assistance.

(d) **Class 4:** 100% when the worker cannot stand without a prosthesis, the help of others, or mechanical support.

(e) When a value is granted under this section, additional impairment values in the same extremity are not allowed for strength loss, chronic condition, reduced range of motion, or limited ability to walk/stand for two hours or less because they have been included in the impairment values shown in this section.

(f) For bilateral extremity loss, each extremity is rated separately.

(11) If there is a diagnosis of Grade IV chondromalacia, extensive arthritis or extensive degenerative joint disease and one or more of the following are present: secondary strength loss; chronic effusion; varus or valgus deformity less than that specified in section (4) of this rule, then one or more of the following rating values apply:

(a) 5% of the foot for the ankle joint; or

(b) 5% of the leg for the knee joint.

(12) For a diagnosis of degenerative joint disease, chondromalacia, or arthritis which does not meet the criteria noted in section (11) of this rule, the impairment is determined under the chronic condition rule (OAR 436-035-0019) if the criteria in that rule is met.

(13) Other impairment values, e.g., weakness, chronic condition, reduced range of motion, etc., are combined with the value granted in section (11) of this rule.

(14) When the worker cannot be on their feet for more than two hours in an 8-hour period, the award is 15% of the leg.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/8/22 as WCD Admin. Order 22-064, eff. 12/4/22

436-035-0235 Conversion of Lower Extremity Values to Whole Person Values

(1) The tables in this rule are used to convert losses in the lower extremity to a whole person (WP) value for claims with a date of injury on or after January 1, 2005.

(2) The following table is used to convert losses in the great toe to a whole person (WP) value. Impairment in any of the other toes receives a whole person value of 1% for each toe that is injured.

Great Toe	WP	Great Toe	WP
1-24% = 1%		59-74% = 4%	
25-41% = 2%		75-91% = 5%	
42-58% = 3%		92-100% = 6%	

(3) The following table is used to convert a loss in the foot to a whole person (WP) value.

Foot	WP	Foot	WP	Foot	WP
1-3% = 1%		35-36% = 15%		68-70% = 29%	
4-5% = 2%		37-39% = 16%		71-72% = 30%	
6-8% = 3%		40-41% = 17%		73-74% = 31%	
9-10% = 4%		42-44% = 18%		75-77% = 32%	
11-13% = 5%		45-46% = 19%		78-79% = 33%	
14-15% = 6%		47-48% = 20%		80-82% = 34%	
16-17% = 7%		49-51% = 21%		83-84% = 35%	
18-20% = 8%		52-53% = 22%		85-86% = 36%	
21-22% = 9%		54-55% = 23%		87-89% = 37%	
23-24% = 10%		56-58% = 24%		90-91% = 38%	
25-27% = 11%		59-60% = 25%		92-94% = 39%	
28-29% = 12%		61-63% = 26%		95-96% = 40%	
30-32% = 13%		64-65% = 27%		97-98% = 41%	
33-34% = 14%		66-67% = 28%		99-100% = 42%	

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(4) The following table is used to convert a loss in the leg to a whole person (WP) value.

Leg	WP	Leg	WP	Leg	WP
1-3% = 1%		36-37% = 17%		70-71% = 33%	
4-5% = 2%		38-39% = 18%		72-73% = 34%	
6-7% = 3%		40-41% = 19%		74-75% = 35%	
8-9% = 4%		42-43% = 20%		76-77% = 36%	
10-11% = 5%		44-45% = 21%		78-79% = 37%	
12-13% = 6%		46-47% = 22%		80-81% = 38%	
14-15% = 7%		48-49% = 23%		82-84% = 39%	
16-18% = 8%		50-52% = 24%		85-86% = 40%	
19-20% = 9%		53-54% = 25%		87-88% = 41%	
21-22% = 10%		55-56% = 26%		89-90% = 42%	
23-24% = 11%		57-58% = 27%		91-92% = 43%	
25-26% = 12%		59-60% = 28%		93-94% = 44%	
27-28% = 13%		61-62% = 29%		95-96% = 45%	
29-30% = 14%		63-64% = 30%		97-98% = 46%	
31-32% = 15%		65-67% = 31%		99-100% = 47%	
33-35% = 16%		68-69% = 32%			

Stat. Auth.: ORS 656.726; Stats. Implemented: ORS 656.214
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0250 Hearing Loss

(1) The following information is provided by the attending physician or reviewed and commented on by the attending physician, under OAR 436-035-0007(5) and (6), to value work-related hearing loss:

(a) A written record, history, examination, diagnosis, opinion, interpretation and a statement noting if further material improvement would reasonably be expected from medical treatment or the passage of time by a medical provider with specialty training or experience in evaluating hearing loss.

(b) The complete audiometric testing.

(2) A worker is eligible for an award for impairment for any loss of normal hearing that results from the compensable injury. Any hearing loss that existed before the compensable injury and that does not result from a compensable pre-existing condition must be offset against hearing loss in the claim if the hearing loss that existed before the compensable injury is adequately documented by a baseline audiogram that was obtained within 180 days of assignment to a high noise environment.

(a) The offset will be done at the monaural percentage of impairment level.

(b) Determine the monaural percentage of impairment for the baseline audiogram under section (4) of this rule.

(c) Subtract the baseline audiogram impairment from the current audiogram impairment to obtain the impairment value.

(3) Hearing loss is based on audiograms which must report on air conduction frequencies at 500, 1,000, 2,000, 3,000, 4,000 and 6,000 Hz.

(a) Audiograms should be based on American National Standards Institute S3.6 (1989) standards.

(b) Test results will be accepted only if they come from a test conducted at least 14 consecutive hours after the worker has been removed from significant exposure to noise.

(4) Impairment of hearing is calculated from the number of decibels by which the worker's hearing exceeds 150 decibels (hearing impairment threshold). Compensation for monaural hearing loss is calculated as follows:

(a) Add the audiogram findings at 500, 1,000, 2,000, 3,000, 4,000 and 6,000 Hz. Decibel readings in excess of 100 will be entered into the computations as 100 dB.

(b) Consult the Monaural Hearing Loss Table below, using the sum of the audiogram findings from subsection (a) of this section. This table will give you the percent of monaural hearing loss to be compensated.

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db	%LOSS	db	%LOSS	db	%LOSS	db	%LOSS
150.00	0.00	201.00	12.75	252.00	25.50	303.00	38.25
151.00	0.25	202.00	13.00	253.00	25.75	304.00	38.50
152.00	0.50	203.00	13.25	254.00	26.00	305.00	38.75
153.00	0.75	204.00	13.50	255.00	26.25	306.00	39.00
154.00	1.00	205.00	13.75	256.00	26.50	307.00	39.25
155.00	1.25	206.00	14.00	257.00	26.75	308.00	39.50
156.00	1.50	207.00	14.25	258.00	27.00	309.00	39.75
157.00	1.75	208.00	14.50	259.00	27.25	310.00	40.00
158.00	2.00	209.00	14.75	260.00	27.50	311.00	40.25
159.00	2.25	210.00	15.00	261.00	27.75	312.00	40.50
160.00	2.50	211.00	15.25	262.00	28.00	313.00	40.75
161.00	2.75	212.00	15.50	263.00	28.25	314.00	41.00
162.00	3.00	213.00	15.75	264.00	28.50	315.00	41.25
163.00	3.25	214.00	16.00	265.00	28.75	316.00	41.50
164.00	3.50	215.00	16.25	266.00	29.00	317.00	41.75
165.00	3.75	216.00	16.50	267.00	29.25	318.00	42.00
166.00	4.00	217.00	16.75	268.00	29.50	319.00	42.25
167.00	4.25	218.00	17.00	269.00	29.75	320.00	42.50
168.00	4.50	219.00	17.25	270.00	30.00	321.00	42.75
169.00	4.75	220.00	17.50	271.00	30.25	322.00	43.00
170.00	5.00	221.00	17.75	272.00	30.50	323.00	43.25
171.00	5.25	222.00	18.00	273.00	30.75	324.00	43.50
172.00	5.50	223.00	18.25	274.00	31.00	325.00	43.75
173.00	5.75	224.00	18.50	275.00	31.25	326.00	44.00
174.00	6.00	225.00	18.75	276.00	31.50	327.00	44.25
175.00	6.25	226.00	19.00	277.00	31.75	328.00	44.50
176.00	6.50	227.00	19.25	278.00	32.00	329.00	44.75
177.00	6.75	228.00	19.50	279.00	32.25	330.00	45.00
178.00	7.00	229.00	19.75	280.00	32.50	331.00	45.25
179.00	7.25	230.00	20.00	281.00	32.75	332.00	45.50
180.00	7.50	231.00	20.25	282.00	33.00	333.00	45.75
181.00	7.75	232.00	20.50	283.00	33.25	334.00	46.00
182.00	8.00	233.00	20.75	284.00	33.50	335.00	46.25
183.00	8.25	234.00	21.00	285.00	33.75	336.00	46.50
184.00	8.50	235.00	21.25	286.00	34.00	337.00	46.75
185.00	8.75	236.00	21.50	287.00	34.25	338.00	47.00
186.00	9.00	237.00	21.75	288.00	34.50	339.00	47.25
187.00	9.25	238.00	22.00	289.00	34.75	340.00	47.50
188.00	9.50	239.00	22.25	290.00	35.00	341.00	47.75
189.00	9.75	240.00	22.50	291.00	35.25	342.00	48.00
190.00	10.00	241.00	22.75	292.00	35.50	343.00	48.25
191.00	10.25	242.00	23.00	293.00	35.75	344.00	48.50
192.00	10.50	243.00	23.25	294.00	36.00	345.00	48.75
193.00	10.75	244.00	23.50	295.00	36.25	346.00	49.00
194.00	11.00	245.00	23.75	296.00	36.50	347.00	49.25
195.00	11.25	246.00	24.00	297.00	36.75	348.00	49.50
196.00	11.50	247.00	24.25	298.00	37.00	349.00	49.75
197.00	11.75	248.00	24.50	299.00	37.25	350.00	50.00
198.00	12.00	249.00	24.75	300.00	37.50	351.00	50.25
199.00	12.25	250.00	25.00	301.00	37.75	352.00	50.50
200.00	12.50	251.00	25.25	302.00	38.00	353.00	50.75

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db	%LOSS	db	%LOSS	db	%LOSS	db	%LOSS
354.00	51.00	404.00	63.50	454.00	76.00	504.00	88.50
355.00	51.25	405.00	63.75	455.00	76.25	505.00	88.75
356.00	51.50	406.00	64.00	456.00	76.50	506.00	89.00
357.00	51.75	407.00	64.25	457.00	76.75	507.00	89.25
358.00	52.00	408.00	64.50	458.00	77.00	508.00	89.50
359.00	52.25	409.00	64.75	459.00	77.25	509.00	89.75
360.00	52.50	410.00	65.00	460.00	77.50	510.00	90.00
361.00	52.75	411.00	65.25	461.00	77.75	511.00	90.25
362.00	53.00	412.00	65.50	462.00	78.00	512.00	90.50
363.00	53.25	413.00	65.75	463.00	78.25	513.00	90.75
364.00	53.50	414.00	66.00	464.00	78.50	514.00	91.00
365.00	53.75	415.00	66.25	465.00	78.75	515.00	91.25
366.00	54.00	416.00	66.50	466.00	79.00	516.00	91.50
367.00	54.25	417.00	66.75	467.00	79.25	517.00	91.75
368.00	54.50	418.00	67.00	468.00	79.50	518.00	92.00
369.00	54.75	419.00	67.25	469.00	79.75	519.00	92.25
370.00	55.00	420.00	67.50	470.00	80.00	520.00	92.50
371.00	55.25	421.00	67.75	471.00	80.25	521.00	92.75
372.00	55.50	422.00	68.00	472.00	80.50	522.00	93.00
373.00	55.75	423.00	68.25	473.00	80.75	523.00	93.25
374.00	56.00	424.00	68.50	474.00	81.00	524.00	93.50
375.00	56.25	425.00	68.75	475.00	81.25	525.00	93.75
376.00	56.50	426.00	69.00	476.00	81.50	526.00	94.00
377.00	56.75	427.00	69.25	477.00	81.75	527.00	94.25
378.00	57.00	428.00	69.50	478.00	82.00	528.00	94.50
379.00	57.25	429.00	69.75	479.00	82.25	529.00	94.75
380.00	57.50	430.00	70.00	480.00	82.50	530.00	95.00
381.00	57.75	431.00	70.25	481.00	82.75	531.00	95.25
382.00	58.00	432.00	70.50	482.00	83.00	532.00	95.50
383.00	58.25	433.00	70.75	483.00	83.25	533.00	95.75
384.00	58.50	434.00	71.00	484.00	83.50	534.00	96.00
385.00	58.75	435.00	71.25	485.00	83.75	535.00	96.25
386.00	59.00	436.00	71.50	486.00	84.00	536.00	96.50
387.00	59.25	437.00	71.75	487.00	84.25	537.00	96.75
388.00	59.50	438.00	72.00	488.00	84.50	538.00	97.00
389.00	59.75	439.00	72.25	489.00	84.75	539.00	97.25
390.00	60.00	440.00	72.50	490.00	85.00	540.00	97.50
391.00	60.25	441.00	72.75	491.00	85.25	541.00	97.75
392.00	60.50	442.00	73.00	492.00	85.50	542.00	98.00
393.00	60.75	443.00	73.25	493.00	85.75	543.00	98.25
394.00	61.00	444.00	73.50	494.00	86.00	544.00	98.50
395.00	61.25	445.00	73.75	495.00	86.25	545.00	98.75
396.00	61.50	446.00	74.00	496.00	86.50	546.00	99.00
397.00	61.75	447.00	74.25	497.00	86.75	547.00	99.25
398.00	62.00	448.00	74.50	498.00	87.00	548.00	99.50
399.00	62.25	449.00	74.75	499.00	87.25	549.00	99.75
400.00	62.50	450.00	75.00	500.00	87.50	550.00	100.00
401.00	62.75	451.00	75.25	501.00	87.75		
402.00	63.00	452.00	75.50	502.00	88.00		
403.00	63.25	453.00	75.75	503.00	88.25		

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(c) No value is allowed for db totals of 150 or less. The value for db totals of 550 or more is 100%.

(5) Binaural hearing loss is calculated as follows:

(a) Find the percent of monaural hearing loss for each ear by using the method listed in section (4) of this rule.

(b) Multiply the percent of loss in the better ear by seven.

(c) Add to that result the percent of loss in the other ear.

(d) Divide this sum by eight. This is the percent of binaural hearing loss to be compensated.

(e) This method is expressed by the formula:

$$\frac{7(A) + B}{8}$$

8

"A" is the percent of hearing loss in the better ear.

"B" is the percent of hearing loss in the other ear.

(6) Use the method (monaural or binaural) which results in the greater impairment.

(7) Tinnitus and other auditory losses may be determined as losses under OAR 436-035-0390.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/8/22 as WCD Admin. Order 22-064, eff. 12/4/22

436-035-0255 Conversion of Hearing Loss Values to Whole Person Values

(1) The following table is used to convert a loss of hearing in one ear to a whole person (WP) value for claims with a date of injury on or after January 1, 2005:

Ear	WP	Ear	WP
1-7%	= 1%	56-60%	= 11%
8-13%	= 2%	61-65%	= 12%
14-18%	= 3%	66-71%	= 13%
19-23%	= 4%	72-76%	= 14%
24-28%	= 5%	77-81%	= 15%
29-34%	= 6%	82-86%	= 16%
35-39%	= 7%	87-92%	= 17%
40-44%	= 8%	93-97%	= 18%
45-49%	= 9%	98-100%	= 19%
50-55%	= 10%		

(2) The following table is used to convert a loss of hearing in two ears to a whole person (WP) value for claims with a date of injury on or after January 1, 2005:

Ears	WP	Ears	WP
1-2%	= 1%	51-52%	= 31%
3-4%	= 2%	53-54%	= 32%
5%	= 3%	55%	= 33%
6-7%	= 4%	56-57%	= 34%
8-9%	= 5%	58-59%	= 35%
10%	= 6%	60%	= 36%
11-12%	= 7%	61-62%	= 37%
13-14%	= 8%	63-64%	= 38%
15%	= 9%	65%	= 39%
16-17%	= 10%	66-67%	= 40%
18-19%	= 11%	68-69%	= 41%
20%	= 12%	70%	= 42%
21-22%	= 13%	71-72%	= 43%
23-24%	= 14%	73-74%	= 44%
25%	= 15%	75%	= 45%
26-27%	= 16%	76-77%	= 46%
28-29%	= 17%	78-79%	= 47%
30%	= 18%	80%	= 48%
31-32%	= 19%	81-82%	= 49%
33-34%	= 20%	83-84%	= 50%
35%	= 21%	85%	= 51%
36-37%	= 22%	86-87%	= 52%
38-39%	= 23%	88-89%	= 53%
40%	= 24%	90%	= 54%
41-42%	= 25%	91-92%	= 55%
43-44%	= 26%	93-94%	= 56%
45%	= 27%	95%	= 57%
46-47%	= 28%	96-97%	= 58%
48-49%	= 29%	98-99%	= 59%
50%	= 30%	100%	= 60%

Stat. Auth.: ORS 656.726;

Stats. Implemented: ORS 656.214

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

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436-035-0260 Visual Loss

(1) Visual loss due to a work-related illness or injury is rated for central visual acuity, integrity of the peripheral visual fields, and ocular motility. For ocular disturbances that cause visual impairment that is not reflected in visual acuity, visual fields or ocular motility refer to section (5) of this rule. Visual loss is measured with best correction, using the lenses recommended by the worker's physician. For lacrimal system disturbances refer to OAR 436-035-0440.

(2) Ratings for loss in central visual acuity are calculated for each eye as follows:

(a) Reports for central visual acuity must be for distance and near acuity.

(b) The ratings for loss of distance acuity are as follows, reported in standard increments of Snellen notation for English and Metric 6:

English	Metric 6	% Loss
20/15	6/5	0
20/20	6/6	0
20/25	6/7.5	5
20/30	6/10	10
20/40	6/12	15
20/50	6/15	25
20/60	6/20	35
20/70	6/22	40
20/80	6/24	45
20/100	6/30	50
20/125	6/38	60
20/150	6/50	70
20/200	6/60	80
20/300	6/90	85
20/400	6/120	90
Able to count fingers at 4 feet		95
Not able to count fingers at 4 feet		100

(c) The ratings for loss of near acuity are as follows: reported in standard increments of Snellen 14/14 notation, Revised Jaeger Standard, or American Point-type notation:

Near Snellen inches	Revised Jaeger Standard	American Point-type	% Loss
14/14	1	3	0
14/18	2	4	0
14/21	3	5	5
14/24	4	6	7
14/28	5	7	10
14/35	6	8	50
14/40	7	9	55
14/45	8	10	60
14/60	9	11	80
14/70	10	12	85
14/80	11	13	87
14/88	12	14	90
14/112	13	21	95
14/140	14	23	98

(d) Once the ratings for near and distance acuity are found, add them and divide by two. The value which results is the rating for lost central visual acuity.

(e) If a lens has been removed and a prosthetic lens implanted, an additional 25%, is to be combined (not added) with the percent loss for central visual acuity to determine total central visual acuity, as shown in table (g).

(f) If a lens has been removed and there is no prosthetic lens implanted, an additional 50% is to be combined (not added) with the percent loss for central visual acuity to determine total central visual acuity, as shown in table (g).

(g) The table below may be substituted for combining central visual acuity and the loss of a lens for a total central visual acuity. The table displays the percent loss of central vision for the range of near and distance acuity combined with lens removal for a total central visual acuity. The upper figure is to be used when the lens is present (as found in (d)), the middle figure is to be used when the lens is absent and a prosthetic lens has been implanted (as found in (e)), and the lower figure is to be used when the lens is absent with no implant (as found in (f)). If near acuity is reported in Revised Jaeger Standard or American Point-type, convert these findings to Near Snellen for rating purposes under (2)(c) of this rule when using this table.

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Rating for distance in feet	Near Snellen rating inches (under (c))						
	<u>14</u> 14	<u>14</u> 18	<u>14</u> 21	<u>14</u> 24	<u>14</u> 28	<u>14</u> 35	<u>14</u> 40
20/15 (d)	0	0	3	4	5	25	28
(e)	25	25	27	28	29	44	46
(f)	50	50	52	52	53	63	64
20/20 (d)	0	0	3	4	5	25	28
(e)	25	25	27	28	29	44	46
(f)	50	50	52	52	53	63	64
20/25 (d)	3	3	5	6	8	28	30
(e)	27	27	29	30	31	46	48
(f)	52	52	53	53	54	64	65
20/30 (d)	5	5	8	9	10	30	33
(e)	29	29	31	32	33	48	50
(f)	53	53	54	55	55	65	67
20/40 (d)	8	8	10	11	13	33	35
(e)	31	31	33	33	35	50	51
(f)	54	54	55	56	57	67	68
20/50 (d)	13	13	15	16	18	38	40
(e)	35	35	36	37	39	54	55
(f)	57	57	58	58	59	69	70
20/60 (d)	18	18	20	21	23	43	45
(e)	39	39	40	41	42	57	59
(f)	59	59	60	61	62	72	73
20/70 (d)	20	20	23	24	25	45	48
(e)	40	40	42	43	44	59	61
(f)	60	60	62	62	63	73	74
20/80 (d)	23	23	25	26	28	48	50
(e)	42	42	44	45	46	61	63
(f)	62	62	63	63	64	74	75
20/100 (d)	25	25	28	29	30	50	53
(e)	44	44	46	47	48	63	65
(f)	63	63	64	65	65	75	77
20/125 (d)	30	30	33	34	35	55	58
(e)	48	48	50	51	51	66	68
(f)	65	65	67	67	68	78	79
20/150 (d)	35	35	38	39	40	60	63
(e)	51	51	54	54	55	70	72
(f)	68	68	69	70	70	80	82
20/200 (d)	40	40	43	44	45	65	68
(e)	55	55	57	58	59	74	76
(f)	70	70	72	72	73	83	84
20/300 (d)	43	43	45	46	48	68	70
(e)	57	57	59	60	61	76	78
(f)	72	72	73	73	74	84	85
20/400 (d)	45	45	48	49	50	70	73
(e)	59	59	61	62	63	78	80
(f)	73	73	74	75	75	85	87
20/800 (d)	48	48	50	51	53	73	75
(e)	61	61	63	63	65	79	81
(f)	74	74	75	76	77	87	88

Rating for distance in feet	Near Snellen rating inches (under (c))						
	<u>14</u> 45	<u>14</u> 60	<u>14</u> 70	<u>14</u> 80	<u>14</u> 88	<u>14</u> 112	<u>14</u> 140
20/15 (d)	30	40	43	44	45	48	49
(e)	48	55	57	58	59	61	62
(f)	65	70	72	72	73	74	75
20/20 (d)	30	40	43	44	45	48	49
(e)	48	55	57	58	59	61	62
(f)	65	70	72	72	73	74	75
20/25 (d)	33	43	45	46	48	50	52
(e)	50	57	59	60	61	63	64
(f)	67	72	73	73	74	75	76
20/30 (d)	35	45	48	49	50	53	54
(e)	51	59	61	62	63	65	66
(f)	68	73	74	75	75	77	77
20/40 (d)	38	48	50	51	53	55	57
(e)	54	61	63	63	65	66	68
(f)	69	74	75	76	77	78	79
20/50 (d)	43	53	55	56	58	60	62
(e)	57	65	66	67	68	70	72
(f)	72	77	78	78	79	80	81
20/60 (d)	48	58	60	61	63	65	67
(e)	61	69	70	71	72	74	75
(f)	74	79	80	81	82	83	84
20/70 (d)	50	60	63	64	65	68	69
(e)	63	70	72	73	74	76	77
(f)	75	80	82	82	83	84	85
20/80 (d)	53	63	65	66	68	70	72
(e)	65	72	74	75	76	78	79
(f)	77	81	83	83	84	85	86
20/100 (d)	55	65	68	69	70	73	74
(e)	66	74	76	77	78	80	81
(f)	78	83	84	85	85	87	87
20/125 (d)	60	70	73	74	75	78	79
(e)	70	78	80	81	81	84	84
(f)	80	85	87	87	88	89	90
20/150 (d)	65	75	78	79	80	83	84
(e)	74	81	84	84	85	87	88
(f)	83	88	89	89	90	92	92
20/200 (d)	70	80	83	84	85	88	89
(e)	78	85	87	88	89	91	92
(f)	85	90	92	92	93	94	95
20/300 (d)	73	83	85	86	88	90	92
(e)	80	87	89	90	91	93	94
(f)	87	92	93	93	94	95	96
20/400 (d)	75	85	88	89	90	93	94
(e)	81	89	91	91	93	94	96
(f)	88	93	94	94	95	97	97
20/800 (d)	78	88	90	91	93	95	97
(e)	84	91	93	93	94	96	98
(f)	89	94	95	96	97	98	99

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(3) Ratings for loss of visual field are based upon the results of field measurements of each eye separately using the Goldmann perimeter with a III/4e stimulus. The results may be scored in either one of the two following methods:

(a) Using the monocular Esterman Grid, count all the printed dots outside or falling on the line marking the extent of the visual field. The number of dots counted is the percentage of visual field loss; or

(b) A perimetric chart may be used which indicates the extent of retained vision for each of the eight standard 45° meridians out to 90°. The directions and normal extent of each meridian are as follows:

Minimal normal extent of peripheral visual field

Direction	Degrees
Temporally	85
Down temporally	85
Down	65
Down nasally	50
Nasally	60
Up nasally	55
Up	45
Up temporally	55
TOTAL	500

(A) Record the extent of retained peripheral visual field along each of the eight meridians. Add (do not combine) these eight figures. Find the corresponding percentage for the total retained degrees by use of the table below.

(B) For loss of a quarter or half field, first find half the sum of the normal extent of the two boundary meridians. Then add to this figure the extent of each meridian included within the retained field. This results in a figure which may be applied in the chart below.

(C) Visual field loss due to scotoma in areas other than the central visual field is rated by adding the degrees lost within the scotoma along affected meridians and subtracting that amount from the retained peripheral field. That figure is then applied to the chart below.

Total degrees retained	% of loss	Total degrees retained	% of loss	Total degrees retained	% of loss
0	100	170	66	340	32
5	99	175	65	345	31
10	98	180	64	350	30
15	97	185	63	355	29
20	96	190	62	360	28
25	95	195	61	365	27
30	94	200	60	370	26
35	93	205	59	375	25
40	92	210	58	380	24
45	91	215	57	385	23
50	90	220	56	390	22
55	89	225	55	395	21
60	88	230	54	400	20
65	87	235	53	405	19
70	86	240	52	410	18
75	85	245	51	415	17
80	84	250	50	420	16
85	83	255	49	425	15
90	82	260	48	430	14
95	81	265	47	435	13
100	80	270	46	440	12
105	79	275	45	445	11
110	78	280	44	450	10
115	77	285	43	455	9
120	76	290	42	460	8
125	75	295	41	465	7
130	74	300	40	470	6
135	73	305	39	475	5
140	72	310	38	480	4
145	71	315	37	485	3
150	70	320	36	490	2
155	69	325	35	495	1
160	68	330	34	500	0
165	67	335	33		

(4) Ratings for ocular motility impairment resulting in binocular diplopia are determined as follows:

(a) Determine the single highest value of loss for diplopia noted on each of the standard 45° meridians as listed in the following table.

(b) Add the values obtained for each meridian to obtain the total impairment for loss of ocular motility. A total of 100% or more is rated as 100% of the eye. As an example: Diplopia on looking horizontally off center from 30 degrees in a left

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direction is valued at 10%. Diplopia in the same eye when looking horizontally off center from 21 to 30 degrees in a right direction is valued at 20%. The impairments for diplopia in both ranges are added, so the impairment rating would be 10% plus 20% resulting in a total loss of ocular motility of 30%.

Direction of gaze	Distance from point of fixation	% of loss
central	central vision to 20 degrees	100
down	21 degrees to 30 degrees	50
down	beyond 30 degrees	30
right	21 degrees to 30 degrees	20
right	beyond 30 degrees	10
down right	21 degrees to 30 degrees	20
down right	beyond 30 degrees	10
left	21 degrees to 30 degrees	20
left	beyond 30 degrees	10
down left	21 degrees to 30 degrees	20
down left	beyond 30 degrees	10
up	beyond 20 degrees	10
up right	beyond 20 degrees	10
up left	beyond 20 degrees	10

(5) To the extent that stereopsis (depth perception), glare disturbances or monocular diplopia causes visual impairment are not reflected in visual acuity, visual field or ocular motility, the losses for visual acuity, visual fields or ocular motility will be combined with an additional 5% when in the opinion of the physician the impairment is moderate, 10% if the impairment is severe.

(6) The total rating for monocular loss is found by combining (not adding) the ratings for loss of central vision, loss of visual field, and loss of ocular motility and loss for other conditions specified in section (5) of this rule.

(7) The total rating for binocular loss is figured as follows:

(a) Find the percent of monocular loss for each eye.

(b) Multiply the percent of loss in the better eye by three.

(c) Add to that result the percent of loss in the other eye.

(d) Divide this sum by four. The result is the total percentage of binocular loss.

(e) This method is expressed by the formula

$$\frac{3(A) + B}{4}$$

"A" is the percent of loss in the better eye;

"B" is the percent of loss in the other eye.

(8) Use the method (monocular or binocular) which results in the greater impairment rating.

(9) Enucleation of an eye is rated at 100% of an eye.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0265 Conversion of Vision Loss Values to Whole Person Values

(1) The following table is used to convert vision loss in one eye to a whole person (WP) value for claims with a date of injury on or after January 1, 2005:

Eye	WP	Eye	WP	Eye	WP
1-4% =	1%	38-40% =	12%	73-75% =	23%
5-8% =	2%	41-43% =	13%	76-79% =	24%
9-11% =	3%	44-46% =	14%	80-82% =	25%
12-14% =	4%	47-49% =	15%	83-85% =	26%
15-17% =	5%	50-53% =	16%	86-88% =	27%
18-20% =	6%	54-56% =	17%	89-91% =	28%
21-24% =	7%	57-59% =	18%	92-95% =	29%
25-27% =	8%	60-62% =	19%	96-98% =	30%
28-30% =	9%	63-66% =	20%	99% =	31%
31-33% =	10%	67-69% =	21%	100% =	31%
34-37% =	11%	70-72% =	22%		

(2) The following table is used to convert vision loss in both eyes to a whole person (WP) value for claims with a date of injury on or after January 1, 2005:

Eyes	WP	Eyes	WP	Eyes	WP	Eyes	WP
1% =	1%	26% =	24%	51% =	48%	76% =	71%
2% =	2%	27% =	25%	52% =	49%	77% =	72%
3% =	3%	28% =	26%	53% =	50%	78% =	73%
4% =	4%	29% =	27%	54% =	51%	79% =	74%
5% =	5%	30% =	28%	55% =	52%	80% =	75%
6% =	6%	31% =	29%	56% =	53%	81% =	76%
7% =	7%	32% =	30%	57% =	54%	82% =	77%
8% =	8%	33% =	31%	58% =	55%	83% =	78%
9% =	8%	34% =	32%	59% =	55%	84% =	79%
10% =	9%	35% =	33%	60% =	56%	85% =	80%
11% =	10%	36% =	34%	61% =	57%	86% =	81%
12% =	11%	37% =	35%	62% =	58%	87% =	82%
13% =	12%	38% =	36%	63% =	59%	88% =	83%
14% =	13%	39% =	37%	64% =	60%	89% =	84%
15% =	14%	40% =	38%	65% =	61%	90% =	85%
16% =	15%	41% =	39%	66% =	62%	91% =	86%
17% =	16%	42% =	39%	67% =	63%	92% =	86%
18% =	17%	43% =	40%	68% =	64%	93% =	87%
19% =	18%	44% =	41%	69% =	65%	94% =	88%
20% =	19%	45% =	42%	70% =	66%	95% =	89%
21% =	20%	46% =	43%	71% =	67%	96% =	90%
22% =	21%	47% =	44%	72% =	68%	97% =	91%
23% =	22%	48% =	45%	73% =	69%	98% =	92%
24% =	23%	49% =	46%	74% =	70%	99% =	93%
25% =	24%	50% =	47%	75% =	71%	100% =	94%

Stat. Auth.: ORS 656.726;

Stats. Implemented: ORS 656.214

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

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436-035-0330 Shoulder Joint

(1) The following ratings are for loss of forward elevation (flexion) in the shoulder joint:

Retained Motion/Percentage of Impairment

0° = 13.0%	30°- 40° = 6.0%	100°-120° = 3.0%
1° = 12.7%	41° = 5.9%	121° = 2.9%
2° = 12.4%	42° = 5.8%	122° = 2.8%
3° = 12.1%	43° = 5.7%	123° = 2.7%
4° = 11.8%	44° = 5.6%	124° = 2.6%
5° = 11.5%	45° = 5.5%	125° = 2.5%
6° = 11.2%	46° = 5.4%	126° = 2.4%
7° = 10.9%	47° = 5.3%	127° = 2.3%
8° = 10.6%	48° = 5.2%	128° = 2.2%
9° = 10.3%	49° = 5.1%	129° = 2.1%
10° = 10.0%	50°- 60° = 5.0%	130°-140° = 2.0%
11° = 9.7%	61° = 4.9%	141° = 1.9%
12° = 9.4%	62° = 4.8%	142° = 1.8%
13° = 9.1%	63° = 4.7%	143° = 1.7%
14° = 8.8%	64° = 4.6%	144° = 1.6%
15° = 8.5%	65° = 4.5%	145° = 1.5%
16° = 8.2%	66° = 4.4%	146° = 1.4%
17° = 7.9%	67° = 4.3%	147° = 1.3%
18° = 7.6%	68° = 4.2%	148° = 1.2%
19° = 7.3%	69° = 4.1%	149° = 1.1%
20° = 7.0%	70°- 90° = 4.0%	150°-170° = 1.0%
21° = 6.9%	91° = 3.9%	171° = 0.9%
22° = 6.8%	92° = 3.8%	172° = 0.8%
23° = 6.7%	93° = 3.7%	173° = 0.7%
24° = 6.6%	94° = 3.6%	174° = 0.6%
25° = 6.5%	95° = 3.5%	175° = 0.5%
26° = 6.4%	96° = 3.4%	176° = 0.4%
27° = 6.3%	97° = 3.3%	177° = 0.3%
28° = 6.2%	98° = 3.2%	178° = 0.2%
29° = 6.1%	99° = 3.1%	179° = 0.1%
		180° = 0.0%

(2) The following ratings are for forward elevation (flexion) ankylosis in the shoulder joint:

Joint Ankylosed at/Percentage of Impairment

0° = 15.0%	50° = 10.0%	80° = 15.0%
1° = 14.7%	51° = 10.2%	81° = 15.1%
2° = 14.4%	52° = 10.4%	82° = 15.2%
3° = 14.1%	53° = 10.6%	83° = 15.3%
4° = 13.8%	54° = 10.8%	84° = 15.4%
5° = 13.5%	55° = 11.0%	85° = 15.5%
6° = 13.2%	56° = 11.2%	86° = 15.6%
7° = 12.9%	57° = 11.4%	87° = 15.7%
8° = 12.6%	58° = 11.6%	88° = 15.8%
9° = 12.3%	59° = 11.8%	89° = 15.9%
10° = 12.0%	60° = 12.0%	90°-100° = 16.0%
11° = 11.7%	61° = 12.1%	101° = 16.1%
12° = 11.4%	62° = 12.2%	102° = 16.2%
13° = 11.1%	63° = 12.3%	103° = 16.3%
14° = 10.8%	64° = 12.4%	104° = 16.4%
15° = 10.5%	65° = 12.5%	105° = 16.5%
16° = 10.2%	66° = 12.6%	106° = 16.6%
17° = 9.9%	67° = 12.7%	107° = 16.7%
18° = 9.6%	68° = 12.8%	108° = 16.8%
19° = 9.3%	69° = 12.9%	109° = 16.9%
20°- 40° = 9.0%	70° = 13.0%	110°-150° = 17.0%
41° = 9.1%	71° = 13.2%	151° = 17.1%
42° = 9.2%	72° = 13.4%	152° = 17.2%
43° = 9.3%	73° = 13.6%	153° = 17.3%
44° = 9.4%	74° = 13.8%	154° = 17.4%
45° = 9.5%	75° = 14.0%	155° = 17.5%
46° = 9.6%	76° = 14.2%	156° = 17.6%
47° = 9.7%	77° = 14.4%	157° = 17.7%
48° = 9.8%	78° = 14.6%	158° = 17.8%
49° = 9.9%	79° = 14.8%	159° = 17.9%
		160°-180° = 18.0%

(3) The following ratings are for loss of backward elevation (extension) in the shoulder joint:

Retained Motion/Percentage of Impairment

0° = 2.0%	7° = 1.3%	44° = 0.6%
1° = 1.9%	8° = 1.2%	45° = 0.5%
2° = 1.8%	9° = 1.1%	46° = 0.4%
3° = 1.7%	10°-40° = 1.0%	47° = 0.3%
4° = 1.6%	41° = 0.9%	48° = 0.2%
5° = 1.5%	42° = 0.8%	49° = 0.1%
6° = 1.4%	43° = 0.7%	50° = 0.0%

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(4) The following ratings are for backward elevation (extension) ankylosis in the shoulder joint:

Joint Ankylosed at/Percentage of Impairment

0°-10° = 15.0%	20°-30° = 16.0%	40° = 17.0%
11° = 15.1%	31° = 16.1%	41° = 17.1%
12° = 15.2%	32° = 16.2%	42° = 17.2%
13° = 15.3%	33° = 16.3%	43° = 17.3%
14° = 15.4%	34° = 16.4%	44° = 17.4%
15° = 15.5%	35° = 16.5%	45° = 17.5%
16° = 15.6%	36° = 16.6%	46° = 17.6%
17° = 15.7%	37° = 16.7%	47° = 17.7%
18° = 15.8%	38° = 16.8%	48° = 17.8%
19° = 15.9%	39° = 16.9%	49° = 17.9%
		50° = 18.0%

(5) The following ratings are for loss of abduction in the shoulder joint:

Retained Motion/Percentage of Impairment

0° = 7.0%	20° - 60° = 4.0%	90°-120° = 2.0%
1° = 6.9%	61° = 3.9%	121° = 1.9%
2° = 6.8%	62° = 3.8%	122° = 1.8%
3° = 6.7%	63° = 3.7%	123° = 1.7%
4° = 6.6%	64° = 3.6%	124° = 1.6%
5° = 6.5%	65° = 3.5%	125° = 1.5%
6° = 6.4%	66° = 3.4%	126° = 1.4%
7° = 6.3%	67° = 3.3%	127° = 1.3%
8° = 6.2%	68° = 3.2%	128° = 1.2%
9° = 6.1%	69° = 3.1%	129° = 1.1%
10° = 6.0%	70°- 80° = 3.0%	130°-160° = 1.0%
11° = 5.8%	81° = 2.9%	161° = 0.9%
12° = 5.6%	82° = 2.8%	162° = 0.8%
13° = 5.4%	83° = 2.7%	163° = 0.7%
14° = 5.2%	84° = 2.6%	164° = 0.6%
15° = 5.0%	85° = 2.5%	165° = 0.5%
16° = 4.8%	86° = 2.4%	166° = 0.4%
17° = 4.6%	87° = 2.3%	167° = 0.3%
18° = 4.4%	88° = 2.2%	168° = 0.2%
19° = 4.2%	89° = 2.1%	169° = 0.1%
		170°-180° = 0.0%

(6) The following ratings are for abduction ankylosis in the shoulder joint:

Joint Ankylosed at/Percentage of Impairment

0° = 8.0%	37° = 5.7%	84° = 8.4%
1° = 7.9%	38° = 5.8%	85° = 8.5%
2° = 7.8%	39° = 5.9%	86° = 8.6%
3° = 7.7%	40°-50° = 6.0%	87° = 8.7%
4° = 7.6%	51° = 6.1%	88° = 8.8%
5° = 7.5%	52° = 6.2%	89° = 8.9%
6° = 7.4%	53° = 6.3%	90°-100° = 9.0%
7° = 7.3%	54° = 6.4%	101° = 9.1%
8° = 7.2%	55° = 6.5%	102° = 9.2%
9° = 7.1%	56° = 6.6%	103° = 9.3%
10° = 7.0%	57° = 6.7%	104° = 9.4%
11° = 6.8%	58° = 6.8%	105° = 9.5%
12° = 6.6%	59° = 6.9%	106° = 9.6%
13° = 6.4%	60°-70° = 7.0%	107° = 9.7%
14° = 6.2%	71° = 7.1%	108° = 9.8%
15° = 6.0%	72° = 7.2%	109° = 9.9%
16° = 5.8%	73° = 7.3%	110°-140° = 10.0%
17° = 5.6%	74° = 7.4%	141° = 10.1%
18° = 5.4%	75° = 7.5%	142° = 10.2%
19° = 5.2%	76° = 7.6%	143° = 10.3%
20°-30° = 5.0%	77° = 7.7%	144° = 10.4%
31° = 5.1%	78° = 7.8%	145° = 10.5%
32° = 5.2%	79° = 7.9%	146° = 10.6%
33° = 5.3%	80° = 8.0%	147° = 10.7%
34° = 5.4%	81° = 8.1%	148° = 10.8%
35° = 5.5%	82° = 8.2%	149° = 10.9%
36° = 5.6%	83° = 8.3%	150°-180° = 11.0%

(7) The following ratings are for loss of adduction in the shoulder joint:

Retained Motion/Percentage of Impairment

0°-30° = 1.0%	34° = 0.6%	38° = 0.2%
31° = 0.9%	35° = 0.5%	39° = 0.1%
32° = 0.8%	36° = 0.4%	40-50° = 0.0%
33° = 0.7%	37° = 0.3%	

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(8) The following ratings are for adduction ankylosis in the shoulder joint:

Joint Ankylosed at/Percentage of Impairment

0° = 8.0%	10° = 9.0%	20°-40° = 10.0%
1° = 8.1%	11° = 9.1%	41° = 10.1%
2° = 8.2%	12° = 9.2%	42° = 10.2%
3° = 8.3%	13° = 9.3%	43° = 10.3%
4° = 8.4%	14° = 9.4%	44° = 10.4%
5° = 8.5%	15° = 9.5%	45° = 10.5%
6° = 8.6%	16° = 9.6%	46° = 10.6%
7° = 8.7%	17° = 9.7%	47° = 10.7%
8° = 8.8%	18° = 9.8%	48° = 10.8%
9° = 8.9%	19° = 9.9%	49° = 10.9%
		50° = 11.0%

(9) The following ratings are for loss of internal rotation in the shoulder joint:

Retained Motion/Percentage of Impairment

0° - 20° = 3.0%	30° - 50° = 2.0%	60° - 70° = 1.0%
21° = 2.9%	51° = 1.9%	71° = 0.9%
22° = 2.8%	52° = 1.8%	72° = 0.8%
23° = 2.7%	53° = 1.7%	73° = 0.7%
24° = 2.6%	54° = 1.6%	74° = 0.6%
25° = 2.5%	55° = 1.5%	75° = 0.5%
26° = 2.4%	56° = 1.4%	76° = 0.4%
27° = 2.3%	57° = 1.3%	77° = 0.3%
28° = 2.2%	58° = 1.2%	78° = 0.2%
29° = 2.1%	59° = 1.1%	79° = 0.1%
		80° - 90° = 0.0%

(10) The following ratings are for internal rotation ankylosis in the shoulder joint:

Joint Ankylosed at/Percentage of Impairment

0°-60° = 4.0%	70° = 5.0%	80° = 6.0%
61° = 4.1%	71° = 5.1%	81° = 6.1%
62° = 4.2%	72° = 5.2%	82° = 6.2%
63° = 4.3%	73° = 5.3%	83° = 6.3%
64° = 4.4%	74° = 5.4%	84° = 6.4%
65° = 4.5%	75° = 5.5%	85° = 6.5%
66° = 4.6%	76° = 5.6%	86° = 6.6%
67° = 4.7%	77° = 5.7%	87° = 6.7%
68° = 4.8%	78° = 5.8%	88° = 6.8%
69° = 4.9%	79° = 5.9%	89° = 6.9%
		90° = 7.0%

(11) The following ratings are for loss of external rotation in the shoulder joint:

Retained Motion/Percentage of Impairment

0° - 50° = 1.0%	54° = 0.6%	58° = 0.2%
51° = 0.9%	55° = 0.5%	59° = 0.1%
52° = 0.8%	56° = 0.4%	60° - 90° = 0.0%
53° = 0.7%	57° = 0.3%	

(12) The following ratings are for external rotation ankylosis in the shoulder joint:

Joint Ankylosed at/Percentage of Impairment

0° = 4.0%	10° - 30° = 5.0%	40° - 60° = 6.0%
1° = 4.1%	31° = 5.1%	61° = 6.1%
2° = 4.2%	32° = 5.2%	62° = 6.2%
3° = 4.3%	33° = 5.3%	63° = 6.3%
4° = 4.4%	34° = 5.4%	64° = 6.4%
5° = 4.5%	35° = 5.5%	65° = 6.5%
6° = 4.6%	36° = 5.6%	66° = 6.6%
7° = 4.7%	37° = 5.7%	67° = 6.7%
8° = 4.8%	38° = 5.8%	68° = 6.8%
9° = 4.9%	39° = 5.9%	69° = 6.9%
		70° - 90° = 7.0%

(13) Shoulder surgery is rated as follows:

Shoulder Surgery	Impairment
Partial resection of either clavicle (no additional value is allowed for multiple partial resections of the clavicle)	5%
Total removal of either clavicle	15%
Partial resection of the acromion (no additional value is allowed for multiple partial resections of the acromion)	5%
Total shoulder arthroplasty	30%
Repeat total shoulder replacement	10%

(14) Chronic dislocations of the shoulder joint or diastasis of a sternal joint, are valued at 15% impairment when a preponderance of medical opinion places permanent new restrictions on the worker which necessitate a reduction in the strength lifting category under OAR 436-035-0012.

(15) When two or more ranges of motion are restricted, add the impairment values for decreased range of motion.

(16) When two or more ankylosis positions are documented, select the one direction representing the largest impairment. That will be the impairment value for the shoulder represented by ankylosis.

(17) Valid losses of strength in the shoulder or back, substantiated by clinical findings, are valued based on the peripheral nerve supplying (innervating) the muscle(s) demonstrating the decreased strength, as described in the following table and as modified under OAR 436-035-0011(7):

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Unilateral Nerve	% Impairment Due to Loss of Strength
Accessory (Spinal Accessory)	10%
Anterior Thoracic (Pectoral)	3%
Axillary	21%
Dorsal Scapular	3%
Long Thoracic	9%
Subscapular	3%
Suprascapular	9%
Thoracodorsal	6%

Example 1: A worker suffers a dislocation of the shoulder. Upon recovery, the attending physician reports 4/5 strength of the deltoid muscle. The axillary nerve innervates the deltoid muscle. Complete loss of the axillary nerve is a 21% impairment value. 4/5 strength, under OAR 436-035-0011(7), is a 20% loss of strength. Final impairment is determined by multiplying 21% by 20% for a final value of 4.2% impairment of the shoulder.

Example 2: A worker suffers a laceration of the long thoracic nerve. Upon recovery, the attending physician reports 0/5 strength of the upper back. The long thoracic nerve has a 9% impairment value. 0/5 strength, under OAR 436-035-0011(7), is 100% loss of strength. Final impairment is determined by multiplying 9% by 100% for a final value of 9% impairment of the upper back.

(18) Multiple or bilateral decreased strength impairment findings are determined by combining the values in section (17) of this rule.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 12/5/05 as WCD Admin. Order 05-074, eff. 1/1/06

436-035-0340 Hip

(1) When a preponderance of objective medical evidence supports findings that reduced ranges of motion of the hip do not involve the pelvis or acetabulum, the impairment determination is valued under OAR 436-035-0220. If the reduced ranges of motion are a residual of pelvic or acetabular involvement, the impairment is determined under this rule.

(2) The following ratings are for loss of forward flexion in the hip joint:

Retained motion/percentage of impairment

0° = 9.0%	30°-40° = 6.0%	70° = 3.0%
1° = 8.9%	41° = 5.9%	71° = 2.9%
2° = 8.8%	42° = 5.8%	72° = 2.8%
3° = 8.7%	43° = 5.7%	73° = 2.7%
4° = 8.6%	44° = 5.6%	74° = 2.6%
5° = 8.5%	45° = 5.5%	75° = 2.5%
6° = 8.4%	46° = 5.4%	76° = 2.4%
7° = 8.3%	47° = 5.3%	77° = 2.3%
8° = 8.2%	48° = 5.2%	78° = 2.2%
9° = 8.1%	49° = 5.1%	79° = 2.1%
10° = 8.0%	50° = 5.0%	80° = 2.0%
11° = 7.9%	51° = 4.9%	81° = 1.9%
12° = 7.8%	52° = 4.8%	82° = 1.8%
13° = 7.7%	53° = 4.7%	83° = 1.7%
14° = 7.6%	54° = 4.6%	84° = 1.6%
15° = 7.5%	55° = 4.5%	85° = 1.5%
16° = 7.4%	56° = 4.4%	86° = 1.4%
17° = 7.3%	57° = 4.3%	87° = 1.3%
18° = 7.2%	58° = 4.2%	88° = 1.2%
19° = 7.1%	59° = 4.1%	89° = 1.1%
20° = 7.0%	60° = 4.0%	90° = 1.0%
21° = 6.9%	61° = 3.9%	91° = 0.9%
22° = 6.8%	62° = 3.8%	92° = 0.8%
23° = 6.7%	63° = 3.7%	93° = 0.7%
24° = 6.6%	64° = 3.6%	94° = 0.6%
25° = 6.5%	65° = 3.5%	95° = 0.5%
26° = 6.4%	66° = 3.4%	96° = 0.4%
27° = 6.3%	67° = 3.3%	97° = 0.3%
28° = 6.2%	68° = 3.2%	98° = 0.2%
29° = 6.1%	69° = 3.1%	99° = 0.1%
		100° = 0.0%

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(3) The following ratings are for forward flexion ankylosis in the hip joint:

Joint ankylosed at/percentage of impairment

0° = 33.0%	34° = 27.2%	68° = 37.4%
1° = 32.7%	35° = 27.5%	69° = 37.7%
2° = 32.4%	36° = 27.8%	70° = 38.0%
3° = 32.1%	37° = 28.1%	71° = 38.3%
4° = 31.8%	38° = 28.4%	72° = 38.6%
5° = 31.5%	39° = 28.7%	73° = 38.9%
6° = 31.2%	40° = 29.0%	74° = 39.2%
7° = 30.9%	41° = 29.3%	75° = 39.5%
8° = 30.6%	42° = 29.6%	76° = 39.8%
9° = 30.3%	43° = 29.9%	77° = 40.1%
10° = 30.0%	44° = 30.2%	78° = 40.4%
11° = 29.6%	45° = 30.5%	79° = 40.7%
12° = 29.2%	46° = 30.8%	80° = 41.0%
13° = 28.8%	47° = 31.1%	81° = 41.3%
14° = 28.4%	48° = 31.4%	82° = 41.6%
15° = 28.0%	49° = 31.7%	83° = 41.9%
16° = 27.6%	50° = 32.0%	84° = 42.2%
17° = 27.2%	51° = 32.3%	85° = 42.5%
18° = 26.8%	52° = 32.6%	86° = 42.8%
19° = 26.4%	53° = 32.9%	87° = 43.1%
20° = 26.0%	54° = 33.2%	88° = 43.4%
21° = 25.6%	55° = 33.5%	89° = 43.7%
22° = 25.2%	56° = 33.8%	90° = 44.0%
23° = 24.8%	57° = 34.1%	91° = 44.3%
24° = 24.4%	58° = 34.4%	92° = 44.6%
25° = 24.0%	59° = 34.7%	93° = 44.9%
26° = 24.4%	60° = 35.0%	94° = 45.2%
27° = 24.8%	61° = 35.3%	95° = 45.5%
28° = 25.2%	62° = 35.6%	96° = 45.8%
29° = 25.6%	63° = 35.9%	97° = 46.1%
30° = 26.0%	64° = 36.2%	98° = 46.4%
31° = 26.3%	65° = 36.5%	99° = 46.7%
32° = 26.6%	66° = 36.8%	100° = 47.0%
33° = 26.9%	67° = 37.1%	

(4) The following ratings are for loss of backward extension in the hip joint:

Retained motion/percentage of impairment

0° = 3.0%	10° = 2.0%	20° = 1.0%
1° = 2.9%	11° = 1.9%	21° = 0.9%
2° = 2.8%	12° = 1.8%	22° = 0.8%
3° = 2.7%	13° = 1.7%	23° = 0.7%
4° = 2.6%	14° = 1.6%	24° = 0.6%
5° = 2.5%	15° = 1.5%	25° = 0.5%
6° = 2.4%	16° = 1.4%	26° = 0.4%
7° = 2.3%	17° = 1.3%	27° = 0.3%
8° = 2.2%	18° = 1.2%	28° = 0.2%
9° = 2.1%	19° = 1.1%	29° = 0.1%
		30° = 0.0%

(5) The following ratings are for backward extension ankylosis of the hip joint:

Joint ankylosed at/percentage of impairment

0° = 33.0%	10° = 38.0%	20° = 43.0%
1° = 33.5%	11° = 38.5%	21° = 43.4%
2° = 34.0%	12° = 39.0%	22° = 43.8%
3° = 34.5%	13° = 39.5%	23° = 44.2%
4° = 35.0%	14° = 40.0%	24° = 44.6%
5° = 35.5%	15° = 40.5%	25° = 45.0%
6° = 36.0%	16° = 41.0%	26° = 45.4%
7° = 36.5%	17° = 41.5%	27° = 45.8%
8° = 37.0%	18° = 42.0%	28° = 46.2%
9° = 37.5%	19° = 42.5%	29° = 46.6%
		30° = 47.0%

(6) The following ratings are for loss of abduction in the hip joint:

Retained motion/percentage of impairment

0° = 8.0%	14° = 5.2%	28° = 2.4%
1° = 7.8%	15° = 5.0%	29° = 2.2%
2° = 7.6%	16° = 4.8%	30° = 2.0%
3° = 7.4%	17° = 4.6%	31° = 1.8%
4° = 7.2%	18° = 4.4%	32° = 1.6%
5° = 7.0%	19° = 4.2%	33° = 1.4%
6° = 6.8%	20° = 4.0%	34° = 1.2%
7° = 6.6%	21° = 3.8%	35° = 1.0%
8° = 6.4%	22° = 3.6%	36° = 0.8%
9° = 6.2%	23° = 3.4%	37° = 0.6%
10° = 6.0%	24° = 3.2%	38° = 0.4%
11° = 5.8%	25° = 3.0%	39° = 0.2%
12° = 5.6%	26° = 2.8%	40° = 0.0%
13° = 5.4%	27° = 2.6%	

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(7) The following ratings are for abduction ankylosis in the hip joint:

Joint ankylosed at/percentage of impairment

0° = 33.0%	14° = 38.2%	28° = 43.2%
1° = 33.4%	15° = 38.5%	29° = 43.6%
2° = 33.8%	16° = 38.8%	30° = 44.0%
3° = 34.2%	17° = 39.1%	31° = 44.3%
4° = 34.6%	18° = 39.4%	32° = 44.6%
5° = 35.0%	19° = 39.7%	33° = 44.9%
6° = 35.4%	20° = 40.0%	34° = 45.2%
7° = 35.8%	21° = 40.4%	35° = 45.5%
8° = 36.2%	22° = 40.8%	36° = 45.8%
9° = 36.6%	23° = 41.2%	37° = 46.1%
10° = 37.0%	24° = 41.6%	38° = 46.4%
11° = 37.3%	25° = 42.0%	39° = 46.7%
12° = 37.6%	26° = 42.4%	40° = 47.0%
13° = 37.9%	27° = 42.8%	

(8) The following ratings are for loss of adduction in the hip joint:

Retained motion/percentage of impairment

0° = 4.0%	7° = 2.6%	14° = 1.2%
1° = 3.8%	8° = 2.4%	15° = 1.0%
2° = 3.6%	9° = 2.2%	16° = 0.8%
3° = 3.4%	10° = 2.0%	17° = 0.6%
4° = 3.2%	11° = 1.8%	18° = 0.4%
5° = 3.0%	12° = 1.6%	19° = 0.2%
6° = 2.8%	13° = 1.4%	20° = 0.0%

(9) The following ratings are for adduction ankylosis in the hip joint:

Joint ankylosed at/percentage of impairment

0° = 33.0%	7° = 37.9%	14° = 42.8%
1° = 33.7%	8° = 38.6%	15° = 43.5%
2° = 34.4%	9° = 39.3%	16° = 44.2%
3° = 35.1%	10° = 40.0%	17° = 44.9%
4° = 35.8%	11° = 40.7%	18° = 45.6%
5° = 36.5%	12° = 41.4%	19° = 46.3%
6° = 37.2%	13° = 42.1%	20° = 47.0%

(10) The following ratings are for loss of internal rotation of the hip joint:

Retained motion/percentage of impairment

0° = 5.0%	14° = 3.6%	28° = 2.2%
1° = 4.9%	15° = 3.5%	29° = 2.1%
2° = 4.8%	16° = 3.4%	30° = 2.0%
3° = 4.7%	17° = 3.3%	31° = 1.8%
4° = 4.6%	18° = 3.2%	32° = 1.6%
5° = 4.5%	19° = 3.1%	33° = 1.4%
6° = 4.4%	20° = 3.0%	34° = 1.2%
7° = 4.3%	21° = 2.9%	35° = 1.0%
8° = 4.2%	22° = 2.8%	36° = 0.8%
9° = 4.1%	23° = 2.7%	37° = 0.6%
10° = 4.0%	24° = 2.6%	38° = 0.4%
11° = 3.9%	25° = 2.5%	39° = 0.2%
12° = 3.8%	26° = 2.4%	40° = 0.0%
13° = 3.7%	27° = 2.3%	

(11) The following ratings are for internal rotation ankylosis of the hip joint:

Joint ankylosed at/percentage of impairment

0° = 33.0%	14° = 38.2%	28° = 43.2%
1° = 33.4%	15° = 38.5%	29° = 43.6%
2° = 33.8%	16° = 38.8%	30° = 44.0%
3° = 34.2%	17° = 39.1%	31° = 44.3%
4° = 34.6%	18° = 39.4%	32° = 44.6%
5° = 35.0%	19° = 39.7%	33° = 44.9%
6° = 35.4%	20° = 40.0%	34° = 45.2%
7° = 35.8%	21° = 40.4%	35° = 45.5%
8° = 36.2%	22° = 40.8%	36° = 45.8%
9° = 36.6%	23° = 41.2%	37° = 46.1%
10° = 37.0%	24° = 41.6%	38° = 46.4%
11° = 37.3%	25° = 42.0%	39° = 46.7%
12° = 37.6%	26° = 42.4%	40° = 47.0%
13° = 37.9%	27° = 42.8%	

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(12) The following ratings are for loss of external rotation of the hip joint:

Retained motion/percentage of impairment

0° = 7.0%	17° = 4.3%	34° = 2.6%
1° = 6.8%	18° = 4.2%	35° = 2.5%
2° = 6.6%	19° = 4.1%	36° = 2.4%
3° = 6.4%	20° = 4.0%	37° = 2.3%
4° = 6.2%	21° = 3.9%	38° = 2.2%
5° = 6.0%	22° = 3.8%	39° = 2.1%
6° = 5.8%	23° = 3.7%	40° = 2.0%
7° = 5.6%	24° = 3.6%	41° = 1.8%
8° = 5.4%	25° = 3.5%	42° = 1.6%
9° = 5.2%	26° = 3.4%	43° = 1.4%
10° = 5.0%	27° = 3.3%	44° = 1.2%
11° = 4.9%	28° = 3.2%	45° = 1.0%
12° = 4.8%	29° = 3.1%	46° = 0.8%
13° = 4.7%	30° = 3.0%	47° = 0.6%
14° = 4.6%	31° = 2.9%	48° = 0.4%
15° = 4.5%	32° = 2.8%	49° = 0.2%
16° = 4.4%	33° = 2.7%	50° = 0.0%

(13) The following ratings are for external rotation ankylosis of the hip joint:

Joint ankylosed at/percentage of impairment

0° = 33.0%	17° = 38.1%	34° = 42.2%
1° = 33.3%	18° = 38.4%	35° = 42.5%
2° = 33.6%	19° = 38.7%	36° = 42.8%
3° = 33.9%	20° = 39.0%	37° = 43.1%
4° = 34.2%	21° = 39.2%	38° = 43.4%
5° = 34.5%	22° = 39.4%	39° = 43.7%
6° = 34.8%	23° = 39.6%	40° = 44.0%
7° = 35.1%	24° = 39.8%	41° = 44.3%
8° = 35.4%	25° = 40.0%	42° = 44.6%
9° = 35.7%	26° = 40.2%	43° = 44.9%
10° = 36.0%	27° = 40.4%	44° = 45.2%
11° = 36.3%	28° = 40.6%	45° = 45.5%
12° = 36.6%	29° = 40.8%	46° = 45.8%
13° = 36.9%	30° = 41.0%	47° = 46.1%
14° = 37.2%	31° = 41.3%	48° = 46.4%
15° = 37.5%	32° = 41.6%	49° = 46.7%
16° = 37.8%	33° = 41.9%	50° = 47.0%

(14) When two or more ankylosis positions are documented, select the one direction representing the largest impairment. That will be the impairment value for the hip represented by ankylosis.

(15) A value of 13% is determined for a total hip replacement (both femoral and acetabular resurfacing or components involved). If a total hip replacement surgery occurs following an earlier femoral head replacement surgery under OAR 436-035-0230(5), both impairment values are rated.

(16) A value of 5% is awarded for a repeat total hip replacement surgery.

(17) Total value for loss of range of motion is obtained by adding (not combining) the values for each range of motion.

(18) The final value for the hip is obtained by combining (not adding) the values in sections (15), (16) and (17) of this rule.

(19) Healed displaced fractures in the hip may cause leg length discrepancies. Impairment is determined under OAR 436-035-0230.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0350 General Spinal Findings

(1) The following ratings are for fractured vertebrae:

(a) For a compression fracture of a single vertebral body:

% of compression	% impairment		
	Cervical	Thoracic	Lumbosacral
1% - 25%	4	2	5
26% - 50%	6	3	7
>50%	10	5	12

(b) A compression fracture followed by a corpectomy receives both the surgical value and the maximum compression fracture value.

(c) A fracture of one or more of the posterior elements of a vertebra (spinous process, pedicles, laminae, articular process, odontoid process, or transverse process) is valued per vertebra as follows:

% impairment		
Cervical	Thoracic	Lumbosacral
4	2	5

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(2) For the purposes of this section, the cervical, thoracic, and lumbosacral regions are considered separate body parts. Values determined within one body part are first added, then the total impairment value is obtained by combining the different body part values. The following values are for surgical procedures performed on the spine.

	% impairment		
	Cervical	Thoracic	Lumbosacral
1st surgical procedure Involving 1 disc, 1 or 2 vertebrae, or any combination	8%	4%	9%
Additional disc(s) or vertebra treated within the same region/body part	Add 1% for each additional disc or vertebra.		
Subsequent surgical procedures	Add 1% for each disc or vertebrae treated.		

(3) For injuries that result in loss of strength in the back, refer to OAR 436-035-0330(17) and (18).

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0360 Spinal Ranges of Motion

(1) For the purpose of determining impairment due to loss of spinal range of motion, sections (2) through (12) of this rule shall apply when the physician uses an inclinometer to measure impairment.

(2) The following ratings are for loss of flexion in the cervical region:

Retained Motion/Percentage of Impairment

0° = 6.0%	20° = 4.0%	40° = 2.0%
1° = 5.9%	21° = 3.9%	41° = 1.9%
2° = 5.8%	22° = 3.8%	42° = 1.8%
3° = 5.7%	23° = 3.7%	43° = 1.7%
4° = 5.6%	24° = 3.6%	44° = 1.6%
5° = 5.5%	25° = 3.5%	45° = 1.5%
6° = 5.4%	26° = 3.4%	46° = 1.4%
7° = 5.3%	27° = 3.3%	47° = 1.3%
8° = 5.2%	28° = 3.2%	48° = 1.2%
9° = 5.1%	29° = 3.1%	49° = 1.1%
10° = 5.0%	30° = 3.0%	50° = 1.0%
11° = 4.9%	31° = 2.9%	51° = 0.9%
12° = 4.8%	32° = 2.8%	52° = 0.8%
13° = 4.7%	33° = 2.7%	53° = 0.7%
14° = 4.6%	34° = 2.6%	54° = 0.6%
15° = 4.5%	35° = 2.5%	55° = 0.5%
16° = 4.4%	36° = 2.4%	56° = 0.4%
17° = 4.3%	37° = 2.3%	57° = 0.3%
18° = 4.2%	38° = 2.2%	58° = 0.2%

19° = 4.1%	39° = 2.1%	59° = 0.1%
		60° = 0.0%

(3) The following ratings are for loss of extension in the cervical region:

Retained Motion/Percentage of Impairment

0° = 6.00%	25° = 4.00%	50° = 2.00%
1° = 5.92%	26° = 3.92%	51° = 1.92%
2° = 5.84%	27° = 3.84%	52° = 1.84%
3° = 5.76%	28° = 3.76%	53° = 1.76%
4° = 5.68%	29° = 3.68%	54° = 1.68%
5° = 5.60%	30° = 3.60%	55° = 1.60%
6° = 5.52%	31° = 3.52%	56° = 1.52%
7° = 5.44%	32° = 3.44%	57° = 1.44%
8° = 5.36%	33° = 3.36%	58° = 1.36%
9° = 5.28%	34° = 3.28%	59° = 1.28%
10° = 5.20%	35° = 3.20%	60° = 1.20%
11° = 5.12%	36° = 3.12%	61° = 1.12%
12° = 5.04%	37° = 3.04%	62° = 1.04%
13° = 4.96%	38° = 2.96%	63° = 0.96%
14° = 4.88%	39° = 2.88%	64° = 0.88%
15° = 4.80%	40° = 2.80%	65° = 0.80%
16° = 4.72%	41° = 2.72%	66° = 0.72%
17° = 4.64%	42° = 2.64%	67° = 0.64%
18° = 4.56%	43° = 2.56%	68° = 0.56%
19° = 4.48%	44° = 2.48%	69° = 0.48%
20° = 4.40%	45° = 2.40%	70° = 0.40%
21° = 4.32%	46° = 2.32%	71° = 0.32%
22° = 4.24%	47° = 2.24%	72° = 0.24%
23° = 4.16%	48° = 2.16%	73° = 0.16%
24° = 4.08%	49° = 2.08%	74° = 0.08%
		75° = 0.00%

(4) The following ratings are for loss of right or left lateral flexion in the cervical region:

Retained Motion/Percentage of Impairment

0° = 4.00%	15° = 2.00%	30° = 1.00%
1° = 3.87%	16° = 1.93%	31° = 0.93%
2° = 3.73%	17° = 1.87%	32° = 0.87%
3° = 3.60%	18° = 1.80%	33° = 0.80%
4° = 3.47%	19° = 1.73%	34° = 0.73%
5° = 3.33%	20° = 1.67%	35° = 0.67%
6° = 3.20%	21° = 1.60%	36° = 0.60%
7° = 3.07%	22° = 1.53%	37° = 0.53%
8° = 2.93%	23° = 1.47%	38° = 0.47%
9° = 2.80%	24° = 1.40%	39° = 0.40%
10° = 2.67%	25° = 1.33%	40° = 0.33%
11° = 2.53%	26° = 1.27%	41° = 0.27%
12° = 2.40%	27° = 1.20%	42° = 0.20%
13° = 2.27%	28° = 1.13%	43° = 0.13%
14° = 2.13%	29° = 1.07%	44° = 0.07%
		45° = 0.00%

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(5) The following ratings are for loss of right or left rotation in the cervical region:

Retained Motion/Percentage of Impairment

0° = 6.0%	27° = 3.3%	54° = 1.30%
1° = 5.9%	28° = 3.2%	55° = 1.25%
2° = 5.8%	29° = 3.1%	56° = 1.20%
3° = 5.7%	30° = 3.0%	57° = 1.15%
4° = 5.6%	31° = 2.9%	58° = 1.10%
5° = 5.5%	32° = 2.8%	59° = 1.05%
6° = 5.4%	33° = 2.7%	60° = 1.00%
7° = 5.3%	34° = 2.6%	61° = 0.95%
8° = 5.2%	35° = 2.5%	62° = 0.90%
9° = 5.1%	36° = 2.4%	63° = 0.85%
10° = 5.0%	37° = 2.3%	64° = 0.80%
11° = 4.9%	38° = 2.2%	65° = 0.75%
12° = 4.8%	39° = 2.1%	66° = 0.70%
13° = 4.7%	40° = 2.0%	67° = 0.65%
14° = 4.6%	41° = 1.95%	68° = 0.60%
15° = 4.5%	42° = 1.90%	69° = 0.55%
16° = 4.4%	43° = 1.85%	70° = 0.50%
17° = 4.3%	44° = 1.80%	71° = 0.45%
18° = 4.2%	45° = 1.75%	72° = 0.40%
19° = 4.1%	46° = 1.70%	73° = 0.35%
20° = 4.0%	47° = 1.65%	74° = 0.30%
21° = 3.9%	48° = 1.60%	75° = 0.25%
22° = 3.8%	49° = 1.55%	76° = 0.20%
23° = 3.7%	50° = 1.50%	77° = 0.15%
24° = 3.6%	51° = 1.45%	78° = 0.10%
25° = 3.5%	52° = 1.40%	79° = 0.05%
26° = 3.4%	53° = 1.35%	80° = 0.00%

(6) The following ratings are for loss of flexion in the thoracic region:

Retained Motion/Percentage of Impairment

0° = 4.00%	17° = 1.87%	34° = 0.80%
1° = 3.87%	18° = 1.80%	35° = 0.75%
2° = 3.73%	19° = 1.73%	36° = 0.70%
3° = 3.60%	20° = 1.67%	37° = 0.65%
4° = 3.47%	21° = 1.60%	38° = 0.60%
5° = 3.33%	22° = 1.53%	39° = 0.55%
6° = 3.20%	23° = 1.47%	40° = 0.50%
7° = 3.07%	24° = 1.40%	41° = 0.45%
8° = 2.93%	25° = 1.33%	42° = 0.40%
9° = 2.80%	26° = 1.27%	43° = 0.35%
10° = 2.67%	27° = 1.20%	44° = 0.30%
11° = 2.53%	28° = 1.13%	45° = 0.25%
12° = 2.40%	29° = 1.07%	46° = 0.20%
13° = 2.27%	30° = 1.00%	47° = 0.15%
14° = 2.13%	31° = 0.95%	48° = 0.10%
15° = 2.00%	32° = 0.90%	49° = 0.05%
16° = 1.93%	33° = 0.85%	50° = 0.00%

(7) The following ratings are for loss of right or left rotation in the thoracic region:

Retained Motion/Percentage of Impairment

0° = 3.0%	10° = 2.0%	20° = 1.0%
1° = 2.9%	11° = 1.9%	21° = 0.9%
2° = 2.8%	12° = 1.8%	22° = 0.8%
3° = 2.7%	13° = 1.7%	23° = 0.7%
4° = 2.6%	14° = 1.6%	24° = 0.6%
5° = 2.5%	15° = 1.5%	25° = 0.5%
6° = 2.4%	16° = 1.4%	26° = 0.4%
7° = 2.3%	17° = 1.3%	27° = 0.3%
8° = 2.2%	18° = 1.2%	28° = 0.2%
9° = 2.1%	19° = 1.1%	29° = 0.1%
		30° = 0.0%

(8) The following ratings are for loss of flexion in the lumbosacral region:

True Lumbar Flexion Angle	
Retained Motion	Spine
0° - 14°	10%
15° - 29°	7%
30° - 44°	4%
45° - 59°	2%
60° +	0%

(9) The following ratings are for loss of extension in the lumbosacral region:

Retained Motion/Percentage of Impairment

0° = 7.0%	9° = 5.2%	18° = 2.4%
1° = 6.8%	10° = 5.0%	19° = 2.2%
2° = 6.6%	11° = 4.6%	20° = 2.0%
3° = 6.4%	12° = 4.2%	21° = 1.6%
4° = 6.2%	13° = 3.8%	22° = 1.2%
5° = 6.0%	14° = 3.4%	23° = 0.8%
6° = 5.8%	15° = 3.0%	24° = 0.4%
7° = 5.6%	16° = 2.8%	25° = 0.0%
8° = 5.4%	17° = 2.6%	

(10) The following ratings are for loss of right or left lateral flexion of the lumbosacral region:

Retained Motion/Percentage of Impairment

0° = 5.0%	9° = 3.2%	18° = 1.4%
1° = 4.8%	10° = 3.0%	19° = 1.2%
2° = 4.6%	11° = 2.8%	20° = 1.0%
3° = 4.4%	12° = 2.6%	21° = 0.8%
4° = 4.2%	13° = 2.4%	22° = 0.6%
5° = 4.0%	14° = 2.2%	23° = 0.4%
6° = 3.8%	15° = 2.0%	24° = 0.2%
7° = 3.6%	16° = 1.8%	25° = 0.0%
8° = 3.4%	17° = 1.6%	

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(11) For a total impairment value due to loss of motion, as measured by inclinometer, in any of the cervical, thoracic or lumbosacral regions, add (do not combine) values for loss of motion for each region.

(12) In order to rate range of motion loss and surgery in one region, combine (do not add) the total range of motion loss in that region with the appropriate total surgical impairment value of the corresponding region. Combine the value from each region to find the total impairment of the spine.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 12/5/05 as WCD Admin. Order 05-074, eff. 1/1/06

436-035-0370 Pelvis

(1) The following ratings are for a fractured pelvis which heals with displacement and deformity:

in the symphysis pubis	15%
in the sacroiliac joint, with diastasis	10%
in the sacrum	10%
in the ischium	10%
in the coccyx, with nonunion or excision	5%
in each inferior or superior ramus	2%
in the ilium	2%
in the acetabulum	Rate only loss of hip motion as in OAR 436-035-0340

(2) A hemipelvectomy receives 25% for the pelvis, and the accompanying loss of the leg is determined under OAR 436-035-0140(1).

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0375 Abdomen

Use the following classifications when impairment has resulted from a permanent and palpable defect in the supporting structures of the abdominal wall:

(1) **Class 1:** 5% for a slight protrusion at the site of the defect with increased abdominal pressure that is readily reducible; or occasional mild discomfort at the site of the defect, which limits the worker in one or more activities of daily living (ADL).

(2) **Class 2:** 15% for frequent or persistent protrusion at the site of the defect with increased pressure that is manually reducible; or frequent discomfort, which limits the worker from heavy lifting, but does not hamper some ADL.

(3) **Class 3:** 25% for persistent, irreducible, or irreparable protrusion at the site of the defect and there is a limitation in the worker's ADL.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 5/5/10 as WCD Admin. Order 10-051, eff. 6/1/10

436-035-0380 Cardiovascular System

(1) Impairments of the cardiovascular system are determined based on objective findings that result in the following

conditions: valvular heart disease, coronary heart disease, hypertensive cardiovascular disease, cardiomyopathies, pericardial disease, or cardiac arrhythmias. Each of these conditions will be described and quantified. In most circumstances, the physician should observe the patient during exercise testing.

(2) **Valvular Heart Disease:** Impairment resulting from work related valvular heart disease is rated according to the following classes:

Class 1 (5% Impairment)

The worker has evidence by physical examination or laboratory studies of valvular heart disease, but no symptoms in the performance of ordinary daily activities or even upon moderately heavy exertion; and

The worker does not require continuous treatment, although prophylactic antibiotics may be recommended at the time of a surgical procedure to reduce the risk of bacterial endocarditis; and

The worker remains free of signs of congestive heart failure; and

There are no signs of ventricular hypertrophy or dilation, and the severity of the stenosis or regurgitation is estimated to be mild; or

In the worker who has recovered from valvular heart surgery, all of the above criteria are met.

Class 2 (20% Impairment)

The worker has evidence by physical examination or laboratory studies of valvular heart disease, and there are no symptoms in the performance of ordinary daily activities, but symptoms develop on moderately heavy physical exertion; or

The worker requires moderate dietary adjustment or drugs to prevent symptoms or to remain free of the signs of congestive heart failure or other consequences of valvular heart disease, such as syncope, chest pain and emboli; or

The worker has signs or laboratory evidence of cardiac chamber hypertrophy or dilation, and the severity of the stenosis or regurgitation is estimated to be moderate, and surgical correction is not feasible or advisable; or

The worker has recovered from valvular heart surgery and meets the above criteria.

Class 3 (40% Impairment)

The worker has signs of valvular heart disease and has slight to moderate symptomatic discomfort during the performance of ordinary daily activities; and

Dietary therapy or drugs do not completely control symptoms or prevent congestive heart failure; and

The worker has signs or laboratory evidence of cardiac chamber hypertrophy or dilation, the severity of the stenosis or regurgitation is estimated to be moderate or severe, and surgical correction is not feasible; or

The worker has recovered from heart valve surgery but continues to have symptoms and signs of congestive heart failure including cardiomegaly.

Class 4 (78% Impairment)

The worker has signs by physical examination of valvular heart disease, and symptoms at rest or in the performance of less than ordinary daily activities; and

Dietary therapy and drugs cannot control symptoms or prevent signs of congestive heart failure; and

The worker has signs or laboratory evidence of cardiac chamber hypertrophy or dilation; and the severity of the stenosis or regurgitation is estimated to be moderate or severe, and surgical correction is not feasible; or

The worker has recovered from valvular heart surgery but continues to have symptoms or signs of congestive heart failure.

(3) Coronary Heart Disease: Impairment resulting from work related coronary heart disease is rated according to the following classes:

Class 1 (5% Impairment)

This class of impairment should be reserved for the worker with an equivocal history of angina pectoris on whom coronary angiography is performed, or for a worker on whom coronary angiography is performed for other reasons and in whom is found less than 50% reduction in the cross sectional area of a coronary artery.

Class 2 (20% Impairment)

The worker has history of a myocardial infarction or angina pectoris that is documented by appropriate laboratory studies, but at the time of evaluation the worker has no symptoms while performing ordinary daily activities or even moderately heavy physical exertion; and

The worker may require moderate dietary adjustment or medication to prevent angina or to remain free of signs and symptoms of congestive heart failure; and

The worker is able to walk on the treadmill or bicycle ergometer and obtain a heart rate of 90% of their predicted maximum heart rate without developing significant ST segment shift, ventricular tachycardia, or hypotension; or

The worker has recovered from coronary artery surgery or angioplasty, remains asymptomatic during ordinary daily activities, and is able to exercise as outlined above. If the worker is taking a beta adrenergic blocking agent, the worker should be able to walk on the treadmill to a level estimated to cause an energy expenditure of at least 10 METS* as a substitute for the heart rate target.

*METS is a term that represents the multiples of resting metabolic energy used for any given activity. One MET is 3.5ml/(kg x min).

Class 3 (40% Impairment)

The worker has a history of myocardial infarction that is documented by appropriate laboratory studies, or angina pectoris that is documented by changes on a resting or exercise ECG or radioisotope study that are suggestive of ischemia; or

The worker has either a fixed or dynamic focal obstruction of at least 50% of a coronary artery, demonstrated by angiography; and

The worker requires moderate dietary adjustment or drugs to prevent frequent angina or to remain free of symptoms and signs of congestive heart failure, but may develop angina pectoris or symptoms of congestive heart failure after moderately heavy physical exertion; or

The worker has recovered from coronary artery surgery or angioplasty, continues to require treatment, and has the symptoms described above.

Class 4 (78% Impairment)

The worker has history of a myocardial infarction that is documented by appropriate laboratory studies or angina pectoris that has been documented by changes of a resting ECG or radioisotope study that are highly suggestive of myocardial ischemia; or

The worker has either fixed or dynamic focal obstruction of at least 50% of one or more coronary arteries, demonstrated by angiography; and

Moderate dietary adjustments or drugs are required to prevent angina or to remain free of symptoms and signs of congestive heart failure, but the worker continues to develop symptoms of angina pectoris or congestive heart failure during ordinary daily activities; or

There are signs or laboratory evidence of cardiac enlargement and abnormal ventricular function; or

The worker has recovered from coronary artery bypass surgery or angioplasty and continues to require treatment and have symptoms as described above.

(4) Hypertensive Cardiovascular Disease: Impairment resulting from work related hypertensive cardiovascular disease is rated according to the following classes:

Class 1 (5% Impairment)

The worker has no symptoms and the diastolic pressures are repeatedly in excess of 90 mm Hg; and

The worker is taking antihypertensive medications but has none of the following abnormalities: (1) abnormal urinalysis or renal function tests; (2) history of hypertensive cerebrovascular disease; (3) evidence of left ventricular hypertrophy; (4) hypertensive vascular abnormalities of the optic fundus, except minimal narrowing of arterioles.

Class 2 (20% Impairment)

The worker has no symptoms and the diastolic pressures are repeatedly in excess of 90 mm Hg; and

The worker is taking antihypertensive medication and has any of the following abnormalities: (1) proteinuria and abnormalities of the urinary sediment, but no impairment of renal function as measured by blood urea nitrogen (BUN) and serum creatinine determinations; (2) history of hypertensive cerebrovascular damage; (3) definite hypertensive changes in the retinal arterioles, including crossing defects or old exudates.

Class 3 (40% Impairment)

The worker has no symptoms and the diastolic pressure readings are consistently in excess of 90 mm Hg; and

The worker is taking antihypertensive medication and has any of the following abnormalities: (1) diastolic pressure readings

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usually in excess of 120 mm Hg; (2) proteinuria or abnormalities in the urinary sediment, with evidence of impaired renal function as measured by elevated BUN and serum creatinine, or by creatinine clearance below 50%; (3) hypertensive cerebrovascular damage with permanent neurological residual; (4) left ventricular hypertrophy based on findings of physical examination, ECG, or chest radiograph, but no symptoms, signs or evidence by chest radiograph of congestive heart failure; or (5) retinopathy, with definite hypertensive changes in the arterioles, such as "copper" or "silver wiring," or A-V crossing changes, with or without hemorrhages and exudates.

Class 4 (78% Impairment)

The worker has a diastolic pressure consistently in excess of 90 mm Hg; and

The worker is taking antihypertensive medication and has any two of the following abnormalities; (1) diastolic pressure readings usually in excess of 120 mm Hg; (2) proteinuria and abnormalities in the urinary sediment, with impaired renal function and evidence of nitrogen retention as measured by elevated BUN and serum creatinine or by creatinine clearance below 50%; (3) hypertensive cerebrovascular damage with permanent neurological deficits; (4) left ventricular hypertrophy; (5) retinopathy as manifested by hypertensive changes in the arterioles, retina, or optic nerve; (6) history of congestive heart failure; or

The worker has left ventricular hypertrophy with the persistence of congestive heart failure despite digitalis and diuretics.

(5) Cardiomyopathy: Impairment resulting from work related cardiomyopathies is rated according to the following classes:

Class 1 (5% Impairment)

The worker is asymptomatic and there is evidence of impaired left ventricular function from physical examination or laboratory studies; and

There is no evidence of congestive heart failure or cardiomegaly from physical examination or laboratory studies.

Class 2 (20% Impairment)

The worker is asymptomatic and there is evidence of impaired left ventricular function from physical examination or laboratory studies; and

Moderate dietary adjustment or drug therapy is necessary for the worker to be free of symptoms and signs of congestive heart failure; or

The worker has recovered from surgery for the treatment of hypertrophic cardiomyopathy and meets the above criteria.

Class 3 (40% Impairment)

The worker develops symptoms of congestive heart failure on greater than ordinary daily activities and there is evidence of abnormal ventricular function from physical examination or laboratory studies; and

Moderate dietary restriction or the use of drugs is necessary to minimize the worker's symptoms, or to prevent the appearance

of signs of congestive heart failure or evidence of it by laboratory study; OR

The worker has recovered from surgery for the treatment of hypertrophic cardiomyopathy and meets the criteria described above.

Class 4 (78% Impairment)

The worker is symptomatic during ordinary daily activities despite the appropriate use of dietary adjustment and drugs, and there is evidence of abnormal ventricular function from physical examination or laboratory studies; or

There are persistent signs of congestive heart failure despite the use of dietary adjustment and drugs; or

The worker has recovered from surgery for the treatment of hypertrophic cardiomyopathy and meets the above criteria.

(6) Pericardial Disease: Impairment resulting from work related pericardial disease is rated according to the following classes:

Class 1 (5% Impairment)

The worker has no symptoms in the performance of ordinary daily activities or moderately heavy physical exertion, but does have evidence from either physical examination or laboratory studies of pericardial heart disease; and

Continuous treatment is not required, and there are no signs of cardiac enlargement, or of congestion of lungs or other organs; or

In the worker who has had surgical removal of the pericardium, there are no adverse consequences of the surgical removal and the worker meets the criteria above.

Class 2 (20% Impairment)

The worker has no symptoms in the performance of ordinary daily activities, but does have evidence from either physical examination or laboratory studies of pericardial heart disease; but

Moderate dietary adjustment or drugs are required to keep the worker free from symptoms and signs of congestive heart failure; or

The worker has signs or laboratory evidence of cardiac chamber hypertrophy or dilation; or

The worker has recovered from surgery to remove the pericardium and meets the criteria above.

Class 3 (40% Impairment)

The worker has symptoms on performance of greater than ordinary daily activities despite dietary or drug therapy, and the worker has evidence from physical examination or laboratory studies, of pericardial heart disease; and

Physical signs are present, or there is laboratory evidence of cardiac chamber enlargement or there is evidence of significant pericardial thickening and calcification; or

The worker has recovered from surgery to remove the pericardium but continues to have the symptoms, signs and laboratory evidence described above.

Class 4 (78% Impairment)

The worker has symptoms on performance of ordinary daily activities in spite of using appropriate dietary restrictions or drugs, and the worker has evidence from physical examination or laboratory studies, of pericardial heart disease; and

The worker has signs or laboratory evidence of congestion of the lungs or other organs; or

The worker has recovered from surgery to remove the pericardium and continues to have symptoms, signs, and laboratory evidence described above.

(7) Arrhythmias: Impairment resulting from work related cardiac arrhythmias* is rated according to the following classes:

Class 1 (5% Impairment)

The worker is asymptomatic during ordinary activities and a cardiac arrhythmia is documented by ECG; and

There is no documentation of three or more consecutive ectopic beats or periods of asystole greater than 1.5 seconds, and both the atrial and ventricular rates are maintained between 50 and 100 beats per minute; and

There is no evidence of organic heart disease.

* If an arrhythmia is a result of organic heart disease, the arrhythmia should be rated separately and combined with the impairment rating for the organic heart disease.

Class 2 (20% Impairment)

The worker is asymptomatic during ordinary daily activities and a cardiac arrhythmia* is documented by ECG; and

Moderate dietary adjustment, or the use of drugs, or an artificial pacemaker, is required to prevent symptoms related to the cardiac arrhythmia; or

The arrhythmia persists and there is organic heart disease.

Class 3 (40% Impairment)

The worker has symptoms despite the use of dietary therapy or drugs or of an artificial pacemaker and a cardiac arrhythmia* is documented with ECG; but

The worker is able to lead an active life and the symptoms due to the arrhythmia are limited to infrequent palpitations and episodes of light-headedness, or other symptoms of temporarily inadequate cardiac output.

Class 4 (78% Impairment)

The worker has symptoms due to documented cardiac arrhythmia* that are constant and interfere with ordinary daily activities; or

The worker has frequent symptoms of inadequate cardiac output documented by ECG to be due to frequent episodes of cardiac arrhythmia; or

The worker continues to have episodes of syncope that are either due to, or have a high probability of being related to, the arrhythmia. To fit into this category of impairment, the symptoms must be present despite the use of dietary therapy, drugs, or artificial pacemakers.

(8) For heart transplants an impairment value of 50% is given. This value is combined with any other findings of impairment of the heart.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/8/22 as WCD Admin. Order 22-064, eff. 12/4/22

436-035-0385 Respiratory System

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

(a) FVC is forced vital capacity.

(b) FEV1 is forced expiratory volume in the first second.

(c) Dco refers to diffusing capacity of carbon monoxide.

(d) VO2 Max is measured exercise capacity.

(2) Lung impairment is rated according to the following classes:

(a) **Class 1:** 0% for FVC greater than or equal to 80% of predicted, and FEV1 greater than or equal to 80% of predicted, and FEV1/FVC greater than or equal to 70%, and Dco greater than or equal to 80% of predicted; or VO2 Max greater than 25 ml/(kg x min).

(b) **Class 2:** 18% for FVC between 60% and 79% of predicted, or FEV1 between 60% and 79% of predicted, or FEV1/FVC between 60% and 69%, or Dco between 60% and 79% of predicted, or VO2 Max greater than or equal to 20 ml/(kg x min) and less than or equal to 25 ml/(kg x min).

(c) **Class 3:** 38% for FVC between 51% and 59% of predicted, or FEV1 between 41% and 59% of predicted, or FEV1/FVC between 41% and 59%, or Dco between 41% and 59% of predicted, or VO2 Max greater than or equal to 15 ml/(kg x min) and less than 20 ml/(kg x min).

(d) **Class 4:** 75% for FVC less than or equal to 50% of predicted, or FEV1 less than or equal to 40% of predicted, or FEV1/FVC less than or equal to 40%, or Dco less than or equal to 40% of predicted, or VO2 Max less than 15 ml/(kg x min).

(3) Lung cancer - All persons with lung cancers as a result of a compensable industrial injury or occupational disease are to be considered Class 4 impaired at the time of diagnosis. At a re-evaluation, one year after the diagnosis is established, if the person is found to be free of all evidence of tumor, then the person should be rated under the physiologic parameters in OAR 436-035-0385(2). If there is evidence of tumor, the person is determined to have Class 4 impairment.

(4) Asthma - Reversible obstructive airway disease is rated under the classes of respiratory impairment described in section (2) of this rule. The impairment is based on the best of three successive tests performed at least one week apart at a time when the patient is receiving optimal medical therapy. In addition, a worker may also have impairment determined under OAR 436-035-0450.

(5) Allergic respiratory responses - For workers who have developed an allergic respiratory response to physical, chemical, or biological agents refer to OAR 436-035-0450. Methacholine inhalation testing is permitted at the discretion of the physician. Where methacholine inhalation testing leaves the worker at risk, level of impairment may be based on review of the medical record.

(6) Impairment from air passage defects is determined according to the following classes:

Class 1 (5% Impairment)

Dyspnea does not occur at rest.

Dyspnea is not produced by walking or climbing stairs freely, performance of other usual activities of daily living, stress, prolonged exertion, hurrying, hill climbing, or recreation requiring intensive effort or similar activity.

Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to 4th ring), lower trachea, bronchi, or complete obstruction of the nose (bilateral), or nasopharynx.

Class 2 (20% Impairment)

Dyspnea does not occur at rest.

Dyspnea is not produced by walking freely on the level, climbing at least one flight of ordinary stairs, or the performance of other usual activities of daily living.

Dyspnea is produced by stress, prolonged exertion, hurrying, hill-climbing, recreation except sedentary forms, or similar activity.

Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to 4th ring), lower trachea, bronchi, or complete obstruction of the nose (bilateral), or nasopharynx.

Class 3 (40% Impairment)

Dyspnea does not occur at rest.

Dyspnea is produced by walking more than one or two blocks on the level or climbing one flight of ordinary stairs even with periods of rest; performance of other usual activities of daily living, stress, hurrying, hill-climbing, recreation or similar activity.

Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to 4th ring), lower trachea, or bronchi.

Class 4 (78% Impairment)

Dyspnea occurs at rest, although worker is not necessarily bedridden.

Dyspnea is aggravated by the performance of any of the usual activities of daily living beyond personal cleansing, dressing, grooming or its equivalent.

Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to 4th ring), lower trachea, or bronchi.

(7) Residual impairment from a lobectomy is valued based on the physiological parameters found under section (2) of this rule.

(8) For injuries that result in impaired ability to speak, the following classes are used to rate the worker's ability to speak in relation to: audibility (ability to speak loudly enough to be heard); intelligibility (ability to articulate well enough to be understood); and functional efficiency (ability to produce a serviceably fast rate of speech and to sustain it over a useful period of time).

(a) **Class 1:** 4% when speech can be produced with sufficient intensity and articular quality to meet most of the needs of

everyday speech communication; some hesitation or slowness of speech may exist; certain phonetic units may be difficult or impossible to produce; listeners may require the speaker to repeat.

(b) **Class 2:** 9% when speech can be produced with sufficient intensity and articular quality to meet many of the needs of everyday speech communication; speech may be discontinuous, hesitant or slow; can be understood by a stranger but may have many inaccuracies; may have difficulty being heard in loud places.

(c) **Class 3:** 18% when speech can be produced with sufficient intensity and articular quality to meet some of the needs of everyday speech communication; often consecutive speech can only be sustained for brief periods; can converse with family and friends but may not be understood by strangers; may often be asked to repeat; has difficulty being heard in loud places; voice tires rapidly and tends to become inaudible after a few seconds.

(d) **Class 4:** 26% when speech can be produced with sufficient intensity and articular quality to meet few of the needs of everyday speech communication; consecutive speech limited to single words or short phrases; speech is labored and impractically slow; can produce some phonetic units but may use approximations that are unintelligible or out of context; may be able to whisper audibly but has no voice.

(e) **Class 5:** 33% for complete inability to meet the needs of everyday speech communication.

(9) Workers with successful permanent tracheostomy or stoma should be rated at 25% impairment of the respiratory system.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/8/22 as WCD Admin. Order 22-064, eff. 12/4/22

436-035-0390 Cranial Nerves/Brain

(1) Impairment of the first cranial nerve (olfactory) resulting in either complete inability to detect odors or alteration of the sense of smell is 3% impairment.

(2) Ratings given for impairment of the second cranial nerve (optic) are rated based on their effects on vision under OAR 436-035-0260.

(3) Ratings given for impairment in the third cranial nerve (oculomotor), fourth cranial nerve (trochlear), and sixth cranial nerve (abducens) are rated based on their effects on ocular motility under OAR 436-035-0260.

(4) Ratings given for impairment of the fifth cranial nerve (trigeminal) are as follows:

(a) For loss or alteration of sensation in the trigeminal distribution on one side: 10%; on both sides: 35%.

(b) The rating given for loss of motor function for each trigeminal Nerve is 5%.

(c) The rating given for loss of motor function of both trigeminal Nerves is determined under OAR 436-035-0385 and 436-035-0420.

(5) Ratings given for impairment of the sixth cranial nerve (abducens) are described in section (3) of this rule.

(6) Ratings given for impairment of the seventh cranial nerve (facial) are as follows:

(a) No rating is given for loss of sensation from impairment of one or both facial nerves.

(b) If impairment of one or both facial nerves results in loss or alteration of the sense of taste, the rating is 3%.

(c) Motor loss on one side of the face due to impairment of the facial nerve is rated at 15% for a complete loss, or 5% for a partial loss.

(d) Motor loss on both sides of the face due to impairment of the facial nerve is rated at 45% for a complete loss, or 20% for a partial loss.

(7) Ratings given for impairment of the eighth cranial nerve (auditory) are determined according to their effects on hearing under OAR 436-035-0250. Other ratings for loss of function most commonly associated with this nerve include the following:

(a) For permanent disturbances resulting in disequilibrium which limits activities the impairment is rated under the following:

(A) **Class 1:** 8% when signs of disequilibrium are present with supporting objective findings and the usual activities of daily living (ADL) are performed without assistance.

(B) **Class 2:** 23% when signs of disequilibrium are present with supporting objective findings and the usual activities of daily living can be performed without assistance, and the worker is unable to operate a motor vehicle.

(C) **Class 3:** 48% when signs of disequilibrium are present with supporting objective findings and the usual ADL cannot be performed without assistance.

(D) **Class 4:** 80% when signs of disequilibrium are present with supporting objective findings and the usual ADL cannot be performed without assistance, and confinement to the home or other facility is necessary.

(b) Tinnitus which by a preponderance of medical opinion requires job modification is valued at 5%. No additional impairment value is allowed for "bilateral" tinnitus.

(8) Ratings given for impairment of the ninth cranial nerve (glossopharyngeal), tenth cranial nerve (vagus), and eleventh cranial nerve (cranial accessory) are as follows:

(a) Impairment of swallowing due to damage to the ninth, tenth, or eleventh cranial nerve is determined under OAR 436-035-0420.

(b) Speech impairment due to damage to the ninth, tenth, or eleventh cranial nerve is rated under the classifications in OAR 436-035-0385(8).

(9) Ratings given for impairment of the twelfth cranial nerve (hypoglossal) are as follows:

(a) No rating is allowed for loss on one side.

(b) Bilateral loss is rated as in section (8) of this rule.

(10) Impairment for injuries to the brain or head is determined based upon a preponderance of medical opinion which applies or describes the following criteria.

(a) The existence and severity of the claimed residuals and impairments must be objectively determined by observation or examination or a preponderance of evidence, and must be within the range reasonably considered to be possible, given the nature of the original injury, based upon a preponderance of medical opinion.

(b) Emotional disturbances which are reactive to other residuals, but which are not directly related to the brain or head injury, such as frustration or depressed mood about memory deficits or work limitations, are not included under these criteria and must be addressed separately.

(c) The distinctions between classes are intended to reflect, at their most fundamental level, the impact of the residuals on two domains: impairment of ADL, and impairment of employment capacity.

(d) Where the residuals from the accepted condition and any direct medical sequelae place the worker between one or more classes, the worker is entitled to be placed in the highest class that describes the worker's impairment. There is no averaging of impairment values when a worker falls between classes.

(e) As used in these rules, episodic neurologic disorder refers to and includes any of the following:

(A) Any type of seizure disorder;

(B) Vestibular disorder, including disturbances of balance or sensorimotor integration;

(C) Neuro-ophthalmologic or oculomotor visual disorder, such as diplopia;

(D) Headaches.

CLASS 1 (10% Impairment)

Cognition: The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 9 or 10; (e.g., the worker is alert and oriented; behavior is appropriate and the worker is able to recall and integrate past and recent events). The worker is independent in ADL. If there are cognitive or memory deficits, they are no more than minimal or "nuisance" level, and do not materially impair ADL, or the type of work the worker may perform.

Language: If there is a language deficit, it is no more than minimal (e.g., language comprehension or production might be less than normal, but it is adequate for daily living).

Emotions/behavior: If there are emotional disturbances or personality changes, they are minimal and occur only transiently during stressful situations and events.

Sleep/alertness: If there are episodic sleep disturbances, fatigue, or lethargy, they are minimal (e.g., any sleeping irregularity, fatigue, or lethargy does not interfere with daily living).

Episodic neurologic disorder: If there is an episodic neurologic disorder, it is completely controlled and does not interfere with daily living.

The fundamental intent of this class is as follows: (1) ADL: The worker has "nuisance" level residual effects of head injury,

which may slightly impact the manner in which ADL are performed, or the subjective ease of performance, but the worker remains fully independent in all ADL; (2) Work capacity: The "nuisance" level residuals may impact the manner in which the worker performs work tasks, or the subjective ease of performance, but the worker is not materially limited in the types of work which can be performed, as compared with pre-injury abilities.

CLASS 2
(30% Impairment)

Cognition: The worker functions at the equivalent Rancho Los Amigos Scale-Revised level of 8 (e.g., the worker is alert and oriented; behavior is appropriate and the worker is able to recall and integrate past and recent events). The worker can perform all ADL independently, but due to mild cognitive or memory deficits, may need to use compensatory strategies or devices such as multiple written reminders, alarms, or digital devices; or may sometimes require more time than normal to complete ADL; or may use occasional reminders, prompts, or minor assistance by others as a compensatory strategy, but is not dependent on others. For example, a spouse may be asked to double-check financial transactions for errors, but the worker can manage all transactions independently if necessary, and is not fundamentally dependent on the spouse for this activity. The cognitive or memory deficits limit the worker's ability to perform some types of jobs, for example, mild attention deficits may preclude work in a busy, multi-taking environment, but the worker is still employable.

Language: Language deficit is mild (e.g., language comprehension or production might occasionally interfere with daily living or limit the worker's ability to perform some types of jobs, but the worker is still employable).

Emotion/behavior: Emotional or behavioral disturbances or personality changes are mild. While they may be disproportionate to the stress or situation, they do not significantly impair the worker's ability to relate to others, or to live with others. They may limit the worker's ability to perform some types of jobs, for example, irritability may preclude jobs with high public contact; but the worker is still employable.

Sleep/alertness: Episodic sleep disturbances, fatigue, or lethargy are mild (e.g., any sleeping irregularity, fatigue, or lethargy only occasionally interferes with daily living). Sleep disturbance, or mild or episodic fatigue or lethargy, may limit the worker's ability to perform some types of jobs, for example, shift work or commercial driving; but the worker is still employable.

Episodic neurologic disorder: Any episodic neurologic disorder is not completely controlled, and results in limits in ADL performance or types of work that may be performed, but the worker is still independent in ADL and is employable. For example, headaches may intermittently interfere with daily living; diplopia which worsens with fatigue may cause the worker to have driving restrictions; vestibular symptoms may limit the worker's ability to operate industrial machinery or cause the worker to avoid heights.

The fundamental intent of this class is as follows: (1) ADL: The worker is independent in all ADL, but may require significant adaptations or modifications in normal patterns or means of ADL in order to achieve ADL-independence; (2) Work capacity: The residuals result in some type of limitation on the worker's employment capacity, restricting the range of employment options that were previously available to the worker, but the worker remains employable in most jobs for which the worker was qualified prior to injury.

CLASS 3
(50% Impairment)

Cognition: The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 7 (e.g., the worker is alert and oriented, behavior is appropriate but the worker has mild to moderate impaired judgment or mild to moderate, functionally significant cognitive or memory deficits). The judgment, cognitive, or memory deficits result in impairment sufficient that the worker regularly requires assistance or supervision in order to perform some ADL. The deficits restrict the worker to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity.

Language: Language deficit is mild to moderate (e.g., language comprehension or production deficits frequently interfere with ADL or restrict the worker to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity).

Emotions/behavior: Emotional or behavioral disturbances or personality changes are moderate, disproportionate to the stress or situation, are present at all times and significantly impair the worker's ability to relate to others or to live with others. The disturbances restrict the worker to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity.

Sleep/alertness: Episodic sleep disturbances, fatigue, or lethargy are moderate. They frequently interfere with daily living, or restrict the worker to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity.

Episodic neurologic disorder: If there is an episodic neurologic disorder, it is not completely controlled. It markedly interferes with daily living. The worker cannot operate industrial machinery, and is restricted to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity.

The fundamental intent of this class is as follows: (1) ADL: The worker is not completely independent in all ADL, and requires some type of supervision, assistance, or guidance from another person at some times for some aspects of ADL; (2) Work capacity: The residuals result in major limitations on the worker's employment capacity with major restrictions or limitations on the worker's range of employment options.

CLASS 4
(75% Impairment)

Cognition: The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 6 (e.g., the worker has impaired judgment or significant memory deficit, such that the worker needs assistance and supervision to perform most ADL and can work only in a sheltered setting).

Language: Language deficit is moderate (e.g., language comprehension is often impaired or language production is often inappropriate or unintelligible).

Emotions/behavior: Emotional or behavioral disturbances or personality changes are moderate to severe, disproportionate to the stress or situation, are present at all times, require the worker to be supervised, or seriously limit the worker's ability to live with others. The worker can work, if at all, only in a sheltered setting.

Sleep/alertness: Episodic sleep disturbances, fatigue, or lethargy are moderate-severe (e.g., they require supervision for daily living). The worker can work, if at all, only in a sheltered setting.

Episodic neurologic disorder: If there is episodic neurologic disorder, it is of such severity and constancy that activities have to be limited and supervised. The worker needs to live in a supervised setting such as a foster home, care facility, or supervised semi-independent residence.

The fundamental intent of this class is as follows: (1) ADL: The worker is basically dependent on others for most aspects of ADL, although the worker may not need direct supervision at all times. (2) Work capacity: The worker is incapable of competitive employment and can work, if at all, only in a sheltered setting.

**CLASS 5
(85% Impairment)**

The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 4-5 (e.g., the worker's behavior is inappropriate, the worker is confused, not reliably oriented to time and place; the worker may be agitated and has a severe memory deficit) and the worker requires assistance and supervision to perform all ADL. Total supervision is required. The worker is incapable of any employment.

**CLASS 6
(95% Impairment)**

The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 1-3. The worker is comatose or the worker's responses to stimuli are localized, inconsistent or delayed.

(11) For the purpose of section (10) of this rule, the Rancho Los Amigos-Revised levels are based upon the "Eight States Levels of Cognitive Recovery" developed at the Rancho Los Amigos Hospital and co-authored by Chris Hagen, PhD, Danese Malkumus, M.A., and Patricia Durham, M.S., in 1972. These levels were revised by Danese Malkumus, M.A., and Kathryn Standenip, O.T.R., in 1974, revised by Chris Hagen, PhD, in 1999 to include ten levels, referred to as Rancho-R.

(12) For brain or head injuries that have resulted in the loss of use or function of any upper or lower extremities, a value may

be allowed for the affected body part(s). Refer to the appropriate section of these standards for that determination.

(13) Headaches that are not a direct result of a brain or head injury (e.g., cervicogenic, sensory input issues, etc.) are given a value of 10% when they interfere with the activities of daily living, affect the worker's ability to regularly perform work, and require continued prescription medication or therapy. If a value for headaches is granted under section (10) of this rule, the value in this section is not granted because it is included in the impairment value for the episodic neurological disorder.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/8/22 as WCD Admin. Order 22-064, eff. 12/4/22

436-035-0395 Spinal Cord

(1) The spinal cord is concerned with sensory, motor, and visceral functions. Permanent impairment can result from various disorders affecting these functions. Spinal cord impairment is determined under the following classes:

(a) **Class 1:** 15% when the worker has spinal cord damage but is able to carry out the activities of daily living independently.

(b) **Class 2:** 35% when the worker is a paraplegic and requires assistive measures or devices for any of the activities of daily living.

(c) **Class 3:** 50% when the worker is a quadriplegic and requires assistive measures or devices for any of the activities of daily living.

(d) **Class 4:** 75% when the worker is a paraplegic or quadriplegic and requires the assistance of another person for any of the activities of daily living.

(e) **Class 5:** 95% when the worker is a paraplegic or quadriplegic and is dependent in all of the activities of daily living.

(f) When a value is granted under section (1) of this rule, no additional impairment value is allowed for reduced range of motion in the spine because it is included in the impairment values shown in this section.

(2) For spinal cord damage that has resulted in the loss of use or function of body part(s) other than upper and lower extremities, a value is given for other affected body part(s) or organ system(s). Refer to the appropriate section of these standards for that determination and combine with impairment valued under this rule.

(3) For spinal cord damage that has resulted in the loss of use or function of any upper or lower extremities, a value is given for the affected body part(s). Refer to the appropriate section of these standards for that determination.

(4) Episodic neurological disorders are determined under OAR 436-035-0390(10).

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0400 Mental Illness

(1) Accepted mental disorders resulting in impairment must be diagnosed by a psychiatrist or other mental health professional

as provided for in a managed care organization certified under OAR chapter 436, Division 015.

(2) Diagnoses of mental disorders for the purposes of these rules follow the guidelines of the *Diagnostic and Statistical Manual of Mental Disorders DSM-IV (1994)*, published by the American Psychiatric Association. A copy of the standards referenced in this rule is available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301, 503-947-7810.

(3) The physician describes permanent changes in mental function in terms of their affect on the worker's activities of daily living (ADLs), as defined in OAR 436-035-0005(1). Additionally, the physician describes the affect on social functioning and deterioration or decompensation in work or work-like settings.

(a) Social functioning refers to an individual's capacity to interact appropriately, communicate effectively, and get along with other individuals.

(b) Deterioration or decompensation in work or work-like settings refers to repeated failure to adapt to stressful circumstances, which causes the individual either to withdraw from that situation or to experience exacerbations with accompanying difficulty in maintaining ADL, social relationships, concentration, persistence, pace, or adaptive behaviors.

(4) Loss of function attributable to permanent worsening of personality disorders may be stated as impairment only if it interferes with the worker's long-term ability to adapt to the ordinary activities and stresses of daily living. Personality disorders are rated as two classes with gradations within each class based on severity:

(a) **Class 1:** minimal (0%), mild (6%), or moderate (11%) when the worker shows little self-understanding or awareness of the mental illness; some problems with judgment; some problems with controlling personal behavior; some ability to avoid serious problems with social and personal relationships; and some ability to avoid self-harm.

(b) **Class 2:** minimal (20%), mild (29%), or moderate (38%) when the worker shows considerable loss of self control; an inability to learn from experience; and causes harm to the community or to the self.

(5) Loss of function attributable to permanent symptoms of affective disorders, anxiety disorders, somatoform disorders, and chronic adjustment disorders is rated under the following classes, with gradations within each class based on the severity of the symptoms/loss of function:

(a) **Class 1:** 0% when one or more of the following residual symptoms are noted:

Anxiety symptoms: Require little or no treatment, are in response to a particular stress situation, produce unpleasant tension while the stress lasts, and might limit some activities.

Depressive symptoms: The ADL can be carried out, but the worker might lack ambition, energy, and enthusiasm. There may be such depression-related, mentally-caused physical

problems as mild loss of appetite and a general feeling of being unwell.

Phobic symptoms: Phobias the worker already suffers from may come into play, or new phobias may appear in a mild form.

Psychophysiological symptoms: Are temporary and in reaction to specific stress. Digestive problems are typical. Any treatment is for a short time and is not connected with any ongoing treatment. Any physical pathology is temporary and reversible. Conversion symptoms or hysterical symptoms are brief and do not occur very often. They might include some slight and limited physical problems (such as weakness or hoarseness) that quickly respond to treatment.

(b) **Class 2:** minimal (6%), mild (23%), or moderate (35%) when one or more of the following residual symptoms/loss of functions are noted:

Anxiety symptoms: May require extended treatment. Specific symptoms may include (but are not limited to) startle reactions, indecision because of fear, fear of being alone, and insomnia. There is no loss of intellect or disturbance in thinking, concentration, or memory.

Depressive symptoms: Last for several weeks. There are disturbances in eating and sleeping patterns, loss of interest in usual activities, and moderate retardation of physical activity. There may be thoughts of suicide. Self-care activities and personal hygiene remain good.

Phobic symptoms: Interfere with normal activities to a mild to moderate degree. Typical reactions include (but are not limited to) a desire to remain at home, a refusal to use elevators, a refusal to go into closed rooms, and an obvious reaction of fear when confronted with a situation that involves a superstition.

Psychophysiological symptoms: Require substantial treatment. Frequent and recurring problems with the organs get in the way of common activities. The problems may include (but are not limited to) diarrhea; chest pains; muscle spasms in the arms, legs, or along the backbone; a feeling of being smothered; and hyperventilation. There is no actual pathology in the organs or tissues. Conversion or hysterical symptoms result in periods of loss of physical function that occur more than twice a year, last for several weeks, and need treatment. Symptoms may include (but are not limited to) temporary hoarseness, temporary blindness, temporary weakness in the arms or the legs. These problems continue to return.

(c) **Class 3:** Minimal (50%), mild (66%), or moderate (81%) when one or more of the following residual symptoms/loss of functions are noted:

Anxiety symptoms: Fear, tension, and apprehension interfere with work or the ADL. Memory and concentration decrease or become unreliable. Long-lasting periods of anxiety keep returning and interfere with personal relationships. The worker needs constant reassurance and comfort from family, friends, and co-workers.

Depressive symptoms: Include an obvious loss of interest in the usual ADL, including eating and self-care. These problems are long-lasting and result in loss of weight and an unkempt

appearance. There may be retardation of physical activity, a preoccupation with suicide, and actual attempts at suicide. The worker may be extremely agitated on a frequent or constant basis.

Phobic symptoms: Existing phobias are intensified. In addition, new phobias develop. This results in bizarre and disruptive behavior. In the most serious cases, the worker may become home-bound, or even room-bound. Persons in this state often carry out strange rituals which require them to be isolated or protected.

Psychophysiological symptoms: Include tissue changes in one or more body systems or organs. These may not be reversible. Typical reactions include (but are not limited to) changes in the wall of the intestine that results in constant digestive and elimination problems. Conversion or hysterical symptoms include loss of physical function that occurs often and lasts for weeks or longer. Evidence of physical change follows such events. A symptomatic period (18 months or more) is associated with advanced negative changes in the tissues and organs. These include (but are not limited to) atrophy of muscles in the legs and arms. A common symptom is general flabbiness.

(6) Psychotic disorders are rated based on perception, thinking process, social behavior, and emotional control. Variations in these aspects of mental function are rated under the following classifications with gradations within each class based on severity:

(a) Class 1: minimal (0%), mild (6%), or moderate (11%) when one or more of the following is established:

Perception: The worker misinterprets conversations or events. It is common for persons with this problem to think others are talking about them or laughing at them.

Thinking process: The worker is absent-minded, forgetful, daydreams too much, thinks slowly, has unusual thoughts that recur, or suffers from an obsession. The worker is aware of these problems and may also show mild problems with judgment. It is also possible that the worker may have little self-understanding or understanding of the problem.

Social behavior: Small problems appear in general behavior, but do not get in the way of social or living activities. Others are not disturbed by them. The worker may be over-reactive or depressed or may neglect self-care and personal hygiene.

Emotional control: The worker may be depressed and have little interest in work or life. The worker may have an extreme feeling of well-being without reason. Controlled and productive activities are possible, but the worker is likely to be irritable and unpredictable.

(b) Class 2: minimal (20%), mild (29%), or moderate (38%) when one or more of the following is established:

Perception: Workers in this state have fairly serious problems in understanding their personal surroundings. They cannot be counted on to understand the difference between daydreams, imagination, and reality. They may have fantasies involving money or power, but they recognize them as fantasies. Because

persons in this state are likely to be overly excited or suffering from paranoia, they are also likely to be domineering, preemptory, irritable, or suspicious.

Thinking process: The thinking process is so disturbed that persons in this state might not realize they are having mental problems. The problems might include (but are not limited to) obsessions, blocking, memory loss serious enough to affect work and personal life, confusion, powerful daydreams or long periods of being deeply lost in thought to no set purpose.

Social behavior: Persons in this state can control their social behavior if they are asked to do so. However, if left on their own, their behavior is so bizarre that others may be concerned. Such behavior might include (but is not limited to) over-activity, disarranged clothing, and talk or gestures which neither make sense nor fit the situation.

Emotional control: Persons in this state suffer a serious loss of control over their emotions. They may become extremely angry for little or no reason, they may cry easily, or they may have an extreme feeling of well-being, causing them to talk too much and to little purpose. These behaviors interfere with living and work and cause concern in others.

(c) Class 3: minimal (50%), mild (63%), or moderate (75%) when one or more of the following is established:

Perception: Workers in this state suffer from frequent illusions and hallucinations. Following the demands of these illusions and hallucinations leads to bizarre and disruptive behavior.

Thinking process: Workers in this state suffer from disturbances in thought that are obvious even to a casual observer. These include an inability to communicate clearly because of slurred speech, rambling speech, primitive language, and an absence of the ability to understand the self or the nature of the problem. Such workers also show poor judgment and openly talk about delusions without recognizing them as such.

Social behavior: Persons in this state are a nuisance or a danger to others. Actions might include interfering with work and other activities, shouting, sudden inappropriate bursts of profanity, carelessness about excretory functions, threatening others, and endangering others.

Emotional control: Workers in this state cannot control their personal behavior. They might be very irritable and overactive or so depressed they become suicidal.

(d) Class 4: 90% for workers who usually need to be placed in a hospital or institution. Medication may help them to a certain extent and the following is established:

Perception: Workers become so obsessed with hallucinations, illusions, and delusions that normal self-care is not possible. Bursts of violence may occur.

Thinking process: Communication is either very difficult or impossible. The worker is responding almost entirely to delusions, illusions, and hallucinations. Evidence of disturbed mental processes may include (but are not limited to) severe confusion, incoherence, irrelevance, refusal to speak, the creation of new words or using existing words in a new manner.

Social behavior: The worker's personal behavior endangers both the worker and others. Poor perceptions, confused thinking, lack of emotional control, and obsessive reaction to hallucinations, illusions, and delusions produce behavior that can result in the worker being inaccessible, suicidal, openly aggressive and assaultive, or even homicidal.

Emotional control: The worker may have either a severe emotional disturbance in which the worker is delirious and uncontrolled or extreme depression in which the worker is silent, hostile, and self-destructive. In either case, lack of control over anger and rage might result in homicidal behavior.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0410 Hematopoietic System

(1) Anemia can be impairing when the cardiovascular system cannot compensate for the effects of the anemia. The following values are given for workers who become anemic:

(a) **Class 1:** 0% when there are no complaints or evidence of disease and the usual activities of daily living can be performed; no blood transfusion is required; and the hemoglobin level is 10-12gm/100ml.

(b) **Class 2:** 30% when there are complaints or evidence of disease and the usual activities of daily living can be performed with some difficulty; no blood transfusion is required; and the hemoglobin level is 8-10gm/100ml.

(c) **Class 3:** 70% when there are signs and symptoms of disease and the usual activities of daily living can be performed with difficulty and with varying amounts of assistance from others; blood transfusion of 2 to 3 units is required every 4 to 6 weeks; and the hemoglobin level is 5-8gm/100ml before transfusion.

(d) **Class 4:** 85% when there are signs and symptoms of disease and the usual activities of daily living cannot be performed without assistance from others; blood transfusion of 2 to 3 units is required every 2 weeks, implying hemolysis of transfused blood; and the hemoglobin level is 5-8gm/100ml before transfusion.

(2) White blood cell system impairments are rated under the following classes:

(a) **Class 1:** 5% when there are symptoms or signs of leukocyte abnormality and no or infrequent treatment is needed and all or most of the activities of daily living can be performed.

(b) **Class 2:** 20% when there are symptoms and signs of leukocyte abnormality and continuous treatment is needed but most of the activities of daily living can be performed.

(c) **Class 3:** 40% when there are symptoms and signs of leukocyte abnormality and continuous treatment is needed and the activities of daily living can be performed with occasional assistance from others.

(d) **Class 4:** 73% when there are symptoms and signs of leukocyte abnormality and continuous treatment is needed and continuous care is required for activities of daily living.

(3) Splenectomy is given an impairment value of 5%.

(4) Hemorrhagic disorders receive 5% impairment if many activities must be avoided and constant endocrine therapy is needed, or anticoagulant treatment with a vitamin K antagonist is required. Hemorrhagic disorders that stem from damage to other organs or body systems are not rated under this section but are rated based on the impairment of the other organ or body system.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0420 Gastrointestinal and Genitourinary Systems

(1) Impairments in mastication (chewing) and deglutition (swallowing) are determined based on the following criteria:

(a) Diet limited to semi-solid or soft foods 8%

(b) Diet limited to liquid foods 25%

(c) Eating requires tube feeding or gastrostomy 50%

(2) Impairment of the upper digestive tract (esophagus, stomach and duodenum, small intestine, pancreas) is valued under the following classes:

Class 1 (3% Impairment)

Symptoms or signs of upper digestive tract disease are present or there is anatomic loss or alteration; and

Continuous treatment is not required; and

Weight can be maintained at the desirable level; or

There are no sequelae after surgical procedures.

Class 2 (15% Impairment)

Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and

Appropriate dietary restrictions and drugs are required for control of symptoms, signs or nutritional deficiency; and

Loss of weight below the "desirable weight"* does not exceed 10%.

Class 3 (35% Impairment)

Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and

Appropriate dietary restrictions and drugs do not completely control symptoms, signs, or nutritional state; or

There is 10-20% loss of weight below the "desirable weight"* which is ascribable to a disorder of the upper digestive tract.

Class 4 (63% Impairment)

Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and

Symptoms are not controlled by treatment; or

There is greater than a 20% loss of weight below the "desirable weight"* which is ascribable to a disorder of the upper digestive tract.

*Desirable weight table:

Desirable weights by sex, height, and body build

The weight charts include 5 lb clothing for men, 3 lb clothing for women, and shoes with 1" heels for both.

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Men

Height (inches)	Weight (pounds)	Weight (pounds)	Weight (pounds)
	Small frame	Medium frame	Large frame
62	128-134	131-141	138-150
63	130-136	133-143	140-153
64	132-138	135-145	142-156
65	134-140	137-148	144-160
66	136-142	139-151	146-164
67	138-145	142-154	149-168
68	140-148	145-157	152-172
69	142-151	148-160	155-176
70	144-154	151-163	158-180
71	146-157	154-166	161-184
72	149-160	157-170	164-188
73	152-164	160-174	168-192
74	155-168	164-178	172-197
75	158-172	167-182	176-202
76	162-176	171-187	181-207

Women

Height (inches)	Weight (pounds)	Weight (pounds)	Weight (pounds)
	Small frame	Medium frame	Large frame
58	102-111	109-121	118-131
59	103-113	111-123	120-134
60	104-115	113-126	122-137
61	106-118	115-129	125-140
62	108-121	118-132	128-143
63	111-124	121-135	131-147
64	114-127	124-138	134-151
65	117-130	127-141	137-155
66	120-133	130-144	140-159
67	123-136	133-147	143-163
68	126-139	136-150	146-167
69	129-142	139-153	149-170
70	132-145	142-156	152-173
71	135-148	145-159	155-176
72	138-151	148-162	158-179

(3) Colonic and rectal impairment is rated under the following classes:

Class 1 (3% Impairment)

Signs and symptoms of colonic or rectal disease are infrequent and of brief duration; and

Limitation of activities, special diet or medication is not required; and

No systemic manifestations are present and weight and nutritional state can be maintained at a desirable level; or

There are no sequelae after surgical procedures.

Class 2 (15% Impairment)

There is objective evidence of colonic or rectal disease or anatomic loss or alteration; and

There are mild gastrointestinal symptoms with occasional disturbances of bowel function, accompanied by moderate pain; and

Minimal restriction of diet or mild symptomatic therapy may be necessary; and

No impairment of nutrition results.

Class 3 (30% Impairment)

There is objective evidence of colonic or rectal disease or anatomic loss or alteration; and

There are moderate to severe exacerbations with disturbance of bowel habit, accompanied by periodic or continual pain; and

Restriction of activity, special diet and drugs are required during attacks; and

There are constitutional manifestations (fever, anemia, or weight loss).

Class 4 (50% Impairment)

There is objective evidence of colonic and rectal disease or anatomic loss or alteration; and

There are persistent disturbances of bowel function present at rest with severe persistent pain; and

Complete limitation of activity, continued restriction of diet, and medication do not entirely control the symptoms; and

There are constitutional manifestations (fever, weight loss, or anemia) present.

(4) Anal impairment is rated under the following classes:

Class 1 (3% Impairment)

Signs of organic anal disease are present or there is anatomic loss or alteration; or

There is mild incontinence involving gas or liquid stool; or

Anal symptoms are mild, intermittent, and controlled by treatment.

Class 2 (13% Impairment)

Signs of organic anal disease are present or there is anatomic loss or alteration; and

Moderate but partial fecal incontinence is present requiring continual treatment; or

Continual anal symptoms are present and incompletely controlled by treatment.

Class 3 (23% Impairment)

Signs of organic anal disease are present and there is anatomic loss or alteration; and

Complete fecal incontinence is present; or

Signs of organic anal disease are present and severe anal symptoms unresponsive or not amenable to therapy are present.

(5) Liver impairment is determined under the following classes:

Class 1 (5% Impairment)

There is objective evidence of persistent liver disease even though no symptoms of liver disease are present; and no history of ascites, jaundice, or bleeding esophageal varices within three years; and

Nutrition and strength are good;

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Biochemical studies indicate minimal disturbance in liver function; or

Primary disorders of bilirubin metabolism are present.

Class 2 (20% Impairment)

There is objective evidence of chronic liver disease even though no symptoms of liver disease are present; and no history of ascites, jaundice, or bleeding esophageal varices within three years; and

Nutrition and strength are good; and

Biochemical studies indicate more severe liver damage than Class 1.

Class 3 (40% Impairment)

There is objective evidence of progressive chronic liver disease, or history of jaundice, ascites, or bleeding esophageal or gastric varices within the past year; and

Nutrition and strength may be affected; or

There is intermittent hepatic encephalopathy.

Class 4 (75% Impairment)

There is objective evidence of progressive chronic liver disease, or persistent ascites or persistent jaundice or bleeding esophageal or gastric varices, with central nervous system manifestations of hepatic insufficiency; and

Nutritional state is poor.

Note: For successful liver transplants a basic impairment value of 50% of the digestive system is given. This is combined with any other impairments of the digestive system.

(6) Biliary tract impairment is determined under the following classes:

(a) **Class 1:** 5% for an occasional episode of biliary tract dysfunction.

(b) **Class 2:** 20% for recurrent biliary tract impairment irrespective of treatment.

(c) **Class 3:** 40% for irreparable obstruction of the bile tract with recurrent cholangitis.

(d) **Class 4:** 75% for persistent jaundice and progressive liver disease due to obstruction of the common bile duct.

(7) Impairment of the upper urinary tract is determined under the following classes:

Class 1 (5% Impairment)

Diminution of upper urinary tract function is present as evidenced by creatinine clearance of 75 to 90 liters/24 hr (52 to 62.5 ml/min), or PSP excretion of 15% to 20% in 15 minutes; or

Intermittent symptoms and signs of upper urinary tract dysfunction are present that do not require continuous treatment or surveillance.

Class 2 (23% Impairment)

Diminution of upper urinary tract function is present as evidenced by creatinine clearance of 60 to 75 liters/24 hr (42 to 52 ml/min), or PSP excretion of 10% to 15% in 15 minutes; or

Although creatinine clearance is greater than 75 liters/24 hr (52 ml/min), or PSP excretion is more than 15% in 15 minutes,

symptoms and signs of upper urinary tract disease or dysfunction necessitate continuous surveillance and frequent treatment.

Class 3 (48% Impairment)

Diminution of upper urinary tract function is present as evidenced by creatinine clearance of 40 to 60 liters/24 hr (28 to 42 ml/min), or PSP excretion of 5% to 10% in 15 minutes; or

Although creatinine clearance is 60 to 75 liters/24 hr (42 to 52 ml/min), or PSP excretion is 10% to 15% in 15 minutes, symptoms and signs of upper urinary tract disease or dysfunction are incompletely controlled by surgical or continuous medical treatment.

Class 4 (78% Impairment)

Diminution of upper urinary tract function is present as evidenced by creatinine clearance below 40 liters/24 hr (28 ml/min), or PSP excretion below 5% in 15 minutes; or

Although creatinine clearance is 40 to 60 liters/24 hr (28 to 42 ml/min), or PSP excretion is 5% to 10% in 15 minutes, symptoms and signs of upper urinary tract disease or dysfunction persist despite surgical or continuous medical treatment.

*Note: The individual with a nephrectomy, as a result of an occupational injury or disease, should be rated as having 10% impairment. This value is to be combined with any other permanent impairment (including any impairment in the remaining kidney) pertinent to the case under consideration. The normal ranges of creatinine clearance are: Males: 130 to 200 liters/24 hr (90 to 139 ml/min). Females: 115 to 180 liters/24 hr (80 to 125 ml/min). The normal PSP excretion is 25% or more in urine in 15 minutes.

Permanent, surgically-created forms of urinary diversion usually are provided to compensate for anatomic loss and to allow for egress of urine. They are evaluated as a part of, and in conjunction with, the assessment of the involved portion of the urinary tract.

Irrespective of how well these diversions function in the preservation of renal integrity and the disposition of urine, the following values for the diversions should be combined with those determined under the criteria previously given for the portion of the urinary tract involved:

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Type of Diversion	% Impairment
Uretero-intestinal	10
Cutaneous ureterostomy without intubation	10
Nephrostomy or intubated ureterostomy	15

(8) Impairment of the bladder: When evaluating permanent impairment of the bladder, the status of the upper urinary tract must also be considered. The appropriate impairment values for both are combined under OAR 436-035-0011(5). Impairment of the bladder is determined under the following classes:

(a) **Class 1:** 5% when the patient has symptoms and signs of bladder disorder requiring intermittent treatment with normal function between episodes of malfunction.

(b) **Class 2:** 18% when (a) there are symptoms or signs of bladder disorder requiring continuous treatment; OR (b) there is good bladder reflex activity, but no voluntary control.

(c) **Class 3:** 30% when the bladder has poor reflex activity, that is, there is intermittent dribbling, and no voluntary control.

(d) **Class 4:** 50% when there is no reflex or voluntary control of the bladder, that is, there is continuous dribbling.

(9) Urethra: When evaluating permanent impairment of the urethra, one must also consider the status of the upper urinary tract and bladder. The values for all parts of the urinary system are combined under OAR 436-035-0011(5). Impairment of the urethra is determined under the following classes:

(a) **Class 1:** 3% when symptoms and signs of urethral disorder are present that require intermittent therapy for control.

(b) **Class 2:** 15% when there are symptoms and signs of a urethral disorder that cannot be effectively controlled by treatment.

(10) Penile sexual dysfunction: When evaluating permanent impairment due to sexual dysfunction of the penis, one must also consider the status of the urethra upper urinary tract and bladder. The values for all parts of the system are combined under OAR 436-035-0011(6). Loss or alteration of the gonads is valued under OAR 436-035-0430. Impairment due to sexual dysfunction of the penis is determined under the following classes:

Class 1

**(Under 40 years old = 12% 40-65 years old = 8%
Over 65 years old = 4%)**

Sexual function is possible, but with varying degrees of difficulty of erection, ejaculation or sensation.

Class 2

**(Under 40 years old = 21% 40-65 years old = 14%
Over 65 years old = 7%)**

Sexual function is possible with sufficient erection, but with impaired ejaculation and sensation.

Class 3

**(Under 40 years old = 30% 40-65 years old = 20%
Over 65 years old = 10%)**

No sexual function is possible.

(11) Cervix/uterus/vagina: When evaluating permanent impairment of the cervix/uterus/vagina, one must also consider the status of the urethra, upper urinary tract and bladder. The values for all parts of the system are combined under OAR 436-035-0011(5). Loss or alteration of the gonads is valued under OAR 436-035-0430. Impairment of the cervix/uterus/vagina is determined under the following classes:

Class 1 (8% Impairment)

Symptoms and signs of disease or deformity of the cervix, uterus, or vagina are present that do not require continuous treatment; or

Cervical stenosis, if present, requires no treatment; or

There is anatomic loss of the cervix, uterus, or vagina in the postmenopausal years.

Class 2 (20% Impairment)

Symptoms and signs of disease or deformity of the cervix, uterus, or vagina are present that require continuous treatment; or

Cervical stenosis, if present, requires periodic treatment.

Class 3 (32% Impairment)

Symptoms and signs of disease or deformity of the cervix, uterus, or vagina are present that are not controlled by treatment; or

Cervical stenosis is complete; or

Anatomic or complete functional loss of the cervix, uterus, or vagina in premenopausal years.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0430 Endocrine System

(1) The assessment of permanent impairment from disorders of the hypothalamic-pituitary axis requires evaluation of (1) primary abnormalities related to growth hormone, prolactin, or ADH; (2) secondary abnormalities in other endocrine glands, such as thyroid, adrenal, and gonads, and; (3) structural and functional disorders of the central nervous system caused by anatomic abnormalities of the pituitary. Each disorder must be evaluated separately, using the standards for rating the nervous system, visual system, and mental and behavioral disorders, and the impairments combined. Impairment of the hypothalamic-pituitary axis is determined under the following classes:

(a) **Class 1:** 5% when controlled effectively with continuous treatment.

(b) **Class 2:** 18% when inadequately controlled by treatment.

(c) **Class 3:** 38% when there are severe symptoms and signs despite treatment.

(2) Impairment of thyroid function results in either hyperthyroidism or hypothyroidism. Hyperthyroidism is not considered to be a cause of permanent impairment, because the hypermetabolic state in practically all patients can be corrected permanently by treatment. After remission of hyperthyroidism, there may be permanent impairment of the visual or cardiovascular systems, which should be evaluated using the appropriate standards for those systems.

Hypothyroidism in most instances can be satisfactorily controlled by the administration of thyroid medication. Occasionally, because of associated disease in other organ systems, full hormone replacement may not be possible. Impairment of thyroid function is determined under the following classes:

(a) **Class 1:** 5% when (a) continuous thyroid therapy is required for correction of the thyroid insufficiency or for maintenance of normal thyroid anatomy; AND (b) the replacement therapy appears adequate based on objective physical or laboratory evidence.

(b) **Class 2:** 18% when (a) symptoms and signs of thyroid disease are present, or there is anatomic loss or alteration; AND (b) continuous thyroid hormone replacement therapy is required for correction of the confirmed thyroid insufficiency; BUT (c) the presence of a disease process in another body system or systems permits only partial replacement of the thyroid hormone.

(3) Parathyroid: Impairment of parathyroid function results in either hyperparathyroidism or hypoparathyroidism.

(a) In most cases of hyperparathyroidism, surgical treatment results in correction of the primary abnormality, although secondary symptoms and signs may persist, such as renal calculi or renal failure, which should be evaluated under the appropriate standards. If surgery fails, or cannot be done, the patient may require long-term therapy, in which case the permanent impairment may be classified under the following:

(A) **Class 1:** 5% when symptoms and signs are controlled with medical therapy.

(B) **Class 2:** 18% when there is persistent mild hypercalcemia, with mild nausea and polyuria.

(C) **Class 3:** 78% when there is severe hypercalcemia, with nausea and lethargy.

(b) Hypoparathyroidism is a chronic condition of variable severity that requires long-term medical therapy in most cases. The severity determines the degree of permanent impairment under the following:

(A) **Class 1:** 3% when symptoms and signs controlled with medical therapy.

(B) **Class 2:** 15% when intermittent hypercalcemia or hypocalcemia, and more frequent symptoms in spite of careful medical attention.

(4) Adrenal cortex: Impairment of the adrenal cortex results in either hypoadrenalism or hyperadrenocorticism.

(a) Hypoadrenalism is a lifelong condition that requires long-term replacement therapy with glucocorticoids or mineralocorticoids for proven hormonal deficiencies.

Impairments are rated as follows:

(A) **Class 1:** 5% when symptoms and signs are controlled with medical therapy.

(B) **Class 2:** 33% when symptoms and signs are controlled inadequately, usually during the course of acute illnesses.

(C) **Class 3:** 78% when severe symptoms of adrenal crisis during major illness, usually due to severe glucocorticoid deficiency or sodium depletion.

(b) Hyperadrenocorticism due to the chronic side effects of nonphysiologic doses of glucocorticoids (iatrogenic Cushing's syndrome) is related to dosage and duration of treatment and includes osteoporosis, hypertension, diabetes mellitus and the effects involving catabolism that result in protein myopathy, striae, and easy bruising. Permanent impairment ranges from 5% to 78%, depending on the severity and chronicity of the disease process for which the steroids are given. On the other hand, with diseases of the pituitary-adrenal axis, impairment may be classified based on severity:

(A) **Class 1:** 5% when minimal, as with hyperadrenocorticism that is surgically correctable by removal of a pituitary or adrenal adenoma.

(B) **Class 2:** 33% when moderate, as with bilateral hyperplasia that is treated with medical therapy or adrenalectomy.

(C) **Class 3:** 78% when severe, as with aggressively metastasizing adrenal carcinoma.

(5) Adrenal medulla: Impairment of the adrenal medulla results from pheochromocytoma and is classified as follows:

(a) **Class 1:** 5% when the duration of hypertension has not led to cardiovascular disease and a benign tumor can be removed surgically.

(b) **Class 2:** 33% when there is inoperable malignant pheochromocytomas, if signs and symptoms of catecholamine excess can be controlled with blocking agents.

(c) **Class 3:** 78% when there is wide metastatic malignant pheochromocytomas, in which symptoms of catecholamine excess cannot be controlled.

(6) Pancreas: Impairment of the pancreas results in either diabetes mellitus or in hypoglycemia.

(a) Diabetes mellitus is rated under the following classes:

(A) **Class 1:** 3% when non-insulin dependent (Type II) diabetes mellitus can be controlled by diet; there may or may not be evidence of diabetic microangiopathy, as indicated by the presence of retinopathy or albuminuria greater than 30 mg/100 ml.

(B) **Class 2:** 8% when non-insulin dependent (Type II) diabetes mellitus; and satisfactory control of the plasma glucose requires both a restricted diet and hypoglycemic medication, either an oral agent or insulin. Evidence of microangiopathy, as indicated by retinopathy or by albuminuria of greater than 30 mg/100 ml, may or may not be present.

(C) **Class 3:** 18% when insulin dependent (Type I) diabetes mellitus is present with or without evidence of microangiopathy.

(D) **Class 4:** 33% when insulin dependent (Type I) diabetes mellitus, and hyperglycemic or hypoglycemic episodes occur frequently in spite of conscientious efforts of both the patient and the attending physician.

(b) Hypoglycemia is rated under the following classes:

(A) **Class 1:** 0% when surgical removal of an islet-cell adenoma results in complete remission of the symptoms and signs of hypoglycemia, and there are no post-operative sequelae.

(B) **Class 2:** 28% when signs and symptoms of hypoglycemia are present, with controlled diet and medications and with effects on the performance of activities of daily living.

(7) Gonadal hormones: A patient with anatomic loss or alteration of the gonads that results in a loss or alteration in the ability to produce and regulate the gonadal hormones receives a value of 3% impairment for unilateral loss or alteration and 5% for bilateral loss or alteration. Loss of the cervix/uterus or penile sexual function is valued under OAR 436-035-0420.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0440 Integument and Lacrimal System

(1) If the worker has developed an immunologic reaction to physical, chemical or biological agents, impairment will also be valued under OAR 436-035-0450.

(2) Impairments of the integumentary system may or may not show signs or symptoms of skin disorder upon examination but are rated under the following classes:

(a) **Class 1:** 3% when with treatment, there is no limitation, or minimal limitation, in the performance of work related activities, although exposure to certain physical or chemical agents might increase limitation temporarily.

(b) **Class 2:** 15% when intermittent treatment is required and there is mild limitation in the performance of some work related activities.

(c) **Class 3:** 38% when continuous treatment is required and there is moderate limitation in the performance of many work related activities.

(d) **Class 4:** 68% when continuous treatment is required, which may include periodic confinement at home or other domicile; and there is moderate to severe limitation in the performance of many work related activities.

(e) **Class 5:** 90% when continuous treatment is required, which necessitates confinement at home or other domicile; and there is severe limitation in the performance of work related activities.

(3) If either too little or too much tearing results in a worker's being restricted from regular work, and the condition is not an immunological reaction, a value is assigned as follows:

(a) **Class 1:** 3% when the reaction is a nuisance but does not prevent most regular work-related activities; or

(b) **Class 2:** 8% when the reaction prevents some regular work-related activities; or

(c) **Class 3:** 13% when the reaction prevents most regular work-related activities.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0450 Immune System

(1) When exposure to physical, chemical, or biological agents has resulted in the development of an immunological response, impairment of the immune system is valued as follows:

(a) **Class 1:** 3% when the reaction is a nuisance but does not prevent most regular work related activities.

(b) **Class 2:** 8% when the reaction prevents some regular work related activities.

(c) **Class 3:** 13% when the reaction prevents most regular work related activities.

(2) An allergy is considered to be an immunologic state and is ratable under this rule.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0500 Rating Standard for Individual Claims

(1) This rule applies to the rating of permanent disability under ORS chapter 656 in individual cases under ORS 656.726(4)(f) which requires the director to determine the rating standard in cases where the director finds that the worker's impairment is not addressed in the disability standards.

(2) Rating standards determined under ORS 656.726(4)(f) will be written into the director's order on reconsideration and will apply solely to the rating of that claim.

Stat. Auth.: ORS 656.726(3), (§7, ch. 270, OL 2007)

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726 (§7, ch. 270, OL 2007)

Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

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WORKERS' COMPENSATION DIVISION
WORKERS' WITH DISABILITIES PROGRAM**

**Administrative
Order No.
08-055**

**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 040
WORKERS WITH DISABILITIES PROGRAM**

Effective July 1, 2008

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436-040-0001 Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.726 and 656.628.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628
Hist.: WCD 6-1983(Admin), f. 12/20/83, eff. 1/1/84

436-040-0002 Purpose

The purpose of these rules is to establish guidelines for the administration of the Workers with Disabilities Program established to encourage the employment or re-employment of workers with disabilities.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08

436-040-0003 Applicability of Rules

(1) These rules are effective July 1, 2008, and apply to all applications for relief submitted prior to May 1, 1990 and all requests for reimbursement from the Workers with Disabilities Program filed with the director on or after July 1, 2008 for injuries occurring on or after November 1, 1981.

(2) These rules carry out the provisions of ORS 656.628.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 6/12/08 as WCD Admin. Order 08-055, eff. 7/1/08

436-040-0005 Definitions

Except where the context requires otherwise, these rules are governed by the following definitions:

(1) "**Compensation**" means all benefits, including medical services and attorney fees, provided for a compensable injury to a subject worker or the worker's beneficiaries. However, it does not include expenses as defined by the National Council on Compensation Insurance, in its Workers' Compensation Statistical Plan, Part IV.

(2) "**Deductible**" means the initial \$1,000 of cumulative compensation paid on qualifying claim(s) applied once per worker with a disability.

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

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

(5) "**Employer**" means an employer who qualifies pursuant to the provisions of ORS 656.017, either as a carrier-insured employer or as a self-insured employer under ORS 656.407.

(6) "**Worker with a disability**" means a worker who is afflicted with, or subject to, any permanent physical or mental impairment, whether congenital or due to an injury or disease, including periodic impairment of consciousness or muscular control of such character that the impairment would prevent the worker from obtaining or retaining employment.

(7) "**Workers with Disabilities Claim Reserve**" means the total anticipated liability (paid plus future reimbursable costs) regardless of any relief granted under the Workers with Disabilities Program.

(8) "**Workers with Disabilities Program**" means the program established under ORS 656.628.

(9) "**Paying Agency**" means the insurer, self-insured employer, or designated representative of the self-insured employer, responsible for paying compensation for a compensable injury.

(10) "**Settlement**" means any agreement produced as a result of the act or process of settling differences between a paying agent and a worker with a disability, or disposition of a claim pursuant to ORS 656.236 or 656.289.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08

436-040-0006 Administration of Rules

For the purpose of administration of the Workers with Disabilities Program, orders of the division are deemed orders of the director.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08

436-040-0008 Administrative Review

(1) If a paying agency or employer is aggrieved by a decision of the division, the director may be petitioned for reconsideration.

(2) The director shall examine the application and such further evidence filed, and enter an order. Copies of the order will be sent to the paying agency, the division, and employer, if applicable. Granting or denying reimbursement from the

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Workers with Disabilities Program is at the sole discretion of the director. Pursuant to ORS 656.628(7), the director's order is final and not subject to review by any court or other administrative body.

(3) In adopting these rules, the director reserves the right to re-examine any liability created against the Workers' Benefit Fund and to modify or terminate such liability, where such action is justified.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08

436-040-0010 Criteria for Eligibility

(1) The criteria used to determine eligibility for relief from the Workers with Disabilities Program are:

(a) Without regard to employer knowledge, a worker must have a permanent physical or mental impairment, whether congenital or due to an injury or disease which would prevent the worker from obtaining or retaining employment. For the purpose of this section, a worker has a pre-existing permanent impairment if it is equal to or greater than twenty five percent (25%) of the whole person.

(b) There must be a subsequent compensable injury or injuries:

(A) To the worker with a disability resulting in cumulative claim(s) costs in excess of \$1,000; or

(B) To other workers employed by the disabled worker's employer resulting in cumulative claim(s) costs in excess of \$1,000.

(c) The insurer or employer must demonstrate that the subsequent injury or injuries:

(A) Would not have been sustained except for the disabled worker's impairment; or

(B) Would not have occurred, to workers of the same employer, except for the act or omission of a worker with a disability which resulted from the disabled worker's impairment; or

(C) Resulted in disability which is at least one-fourth greater by reason of the worker's pre-existing impairment, as determined by the division.

(2) An employer declared noncomplying in accordance with ORS 656.052 is not eligible for relief from the Workers with Disabilities Program for injuries to subject workers occurring during any period of noncompliance.

(3) A paying agency is not eligible for reimbursement from the Workers with Disabilities Program for any claim occurring to a worker during a period for which the employer is receiving premium reimbursement from the Re-employment Assistance Program, for that worker, pursuant to ORS 656.622(3).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08

436-040-0020 Limitation of Program

(1) Reimbursement is limited to the monies available in the Workers' Benefit Fund.

(2) In the event of insufficient reserves in the Workers' Benefit Fund, the director shall have final authority to determine an equitable distribution which will proportionately distribute the available funds among the claims which have qualified for reimbursement from the Workers with Disabilities Program.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08

436-040-0030 Application for Determination of Relief From the Workers with Disabilities Program

(1) The paying agency must provide the director adequate evidence to establish eligibility for determination of relief from the Workers with Disabilities Program.

(2) When the deductible has been met and possible eligibility for relief becomes known, the paying agency shall make prompt application to the division requesting determination of relief from the Workers with Disabilities Program in a form prescribed by the director.

(3) The application shall be submitted prior to the date of the last valuation affecting an employer's experience rating, prior to the last valuation for retrospective rating, whichever is the last to occur and prior to the employer ceasing to do business. The application shall be supported by sufficient evidence establishing eligibility for reimbursement under the general provisions herein and in accordance with OAR 436-040-0010. For employers that are not experience rated, application shall be submitted prior to the date there would have been a last valuation, had the employer been so rated, and prior to the employer ceasing to do business. The preceding application time frames do not apply to self-insured employers or their paying agencies.

(4) To meet the requirements of OAR 436-040-0030(3), the paying agency shall:

(a) Specify the condition which caused permanent impairment and which constituted a handicap;

(b) Specify whether this request is based on a causal or contributory relationship pursuant to OAR 436-040-0010(1)(c);

(c) Provide documentation describing prior impairment: such as medical reports, direct information from the worker, employer documentation, prior Determination Orders, Opinion and Orders, and Orders on Review;

(5) The division will review the application to assure it is complete and the \$1,000 deductible has been met. The application, supporting documentation, and claims involved will then be submitted to the division for an eligibility determination.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08

436-040-0040 Eligibility Determination

(1) The division shall determine whether a claim qualifies for reimbursement, and the percentage of the reimbursement.

(2) The division shall issue a determination order accepting or denying the application within 30 calendar days after receipt of the application and supporting documentation.

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(3) The reimbursement percentage shown on the determination order will be:

(a) 100% after the \$1,000 deductible in those cases qualifying under OAR 436-040-0010(1)(c)(A) and (B); or

(b) In direct proportion to the percentage the resulting disability was increased as a result of the pre-existing impairment in those cases qualifying under OAR 436-040-0010(1)(c)(C).

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.628

Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08

436-040-0050 Reimbursement

(1) Reimbursement will be made to the paying agency based on the percentage of reimbursement ordered by the division.

(2) Request for reimbursement shall not be made until the deductible has been met.

(3) Requests for reimbursement are not to include: costs incurred for conditions unrelated to the compensable claim; costs incurred due to inaccurate, untimely, or improper processing; expenses; and settlement amounts not approved by the division, to which the parties agreed after relief was granted.

(4) The division will authorize reimbursement to the paying agency quarterly after receipt and approval of documentation of compensation paid from the paying agency. Documentation shall include, but not be limited to:

(a) Net amounts paid separated into disability benefits by type, and medical benefits for corresponding quarterly time periods;

(b) The current Worker with a Disability Claim Reserve as defined in these rules;

(c) Payment certification statement; and

(d) Any other information deemed necessary by the director.

(5) For purposes of subsection 4(a) of this rule, "net amounts paid" means the total compensation paid less any recoveries, including but not limited to, third party recovery, Retroactive Program reimbursement and Rehabilitation Program reimbursement.

(6) Periodically the division will audit the physical file of the paying agency to validate the amount reimbursed. Reimbursement shall not be approved if, upon such audit, any of the following are found to apply:

(a) Compensation has been paid as a result of untimely, inaccurate, or improper claims processing;

(b) Compensation has been paid for treatment of any condition unrelated to the compensable claim for which Workers with Disabilities Program relief was granted.

(c) The compensability of the accepted claim is questionable and the rationale for acceptance has not been reasonably documented, as required under generally accepted claims management procedures;

(d) The separate payments of compensation have not been documented, as required under generally accepted accounting procedures;

(e) For applications received after January 1, 1990, the subject employer was no longer doing business at the time of application for the Workers with Disabilities Program determination; that the employer was on a retrospective rating plan that was closed prior to the application for the Workers with Disabilities Program determination; or, if not on an open retrospective rating plan, that the last valuation for experience rating modification purposes that could affect the employer was completed prior to the application for the Workers with Disabilities Program determination;

(f) The insurer did not adjust the claims reserve value used in dividend, retrospective evaluation, or any claim valuation for experience rating determination to the percentage level specified in the order of acceptance, allowing for the \$1,000 compensation minimum, or did not make the necessary monetary adjustments with the employer; or

(g) The insurance carrier is not able to provide applicable records relating to experience rating, retrospective rating or dividend calculations at the time of audit or within ten working days thereafter. Any reimbursements received on claims, for which the insurer is unable to provide records, will be returned to the division at least until the next annual audit is conducted and all applicable records are reviewed.

(7) The division will authorize reimbursement to insurance companies only for compensation which could reasonably be projected at the first of either to occur;

(a) The last claim evaluation which would affect the employer's experience rating modification or retrospective rating adjustment, whichever is later; or

(b) For applications received after January 1, 1990, the employer ceases to do business, if that occurs first.

(8) The insurance company shall submit a claim valuation to the division at the first to occur of:

(a) The last claim valuation date which would affect the employer's experience rating modification or retrospective rating adjustment, whichever is later (usually three and one half years after the inception of the policy period); or

(b) For applications received after January 1, 1990, the employer ceases to do business. The valuation shall include future reserves for the claim at that time. The division will verify the future reserves are reasonable and based on the appropriate valuation date. If the division determines the submitted claim valuation is unreasonable or based on inappropriate information, the division may establish the claim valuation or adjust the claim valuation period. The claim valuation, when approved by the division, shall be the maximum Worker with a Disability Claim Reserve used as the basis for reimbursement for the claim.

(9) When a claim is settled by a Compromise and Release or a Disputed Claims Settlement, the department shall review and modify the final reserve to reflect resulting changes in liability. The paying agent shall be notified of any change in the final reserve. A director review of this action will be considered only when paid claim costs have exceeded the established reserve.

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(10) In the event that a denied claim is found compensable by a hearing referee, the Workers' Compensation Board, or the Court of Appeals, and that decision is reversed by a higher level of appeal, the paying agency shall receive reimbursement for claim payments required to be made while the claim was in accepted status.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)

Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08

436-040-0060 Effects on Rates; Reporting

(1) Where an order of acceptance has established the percentage of reimbursement to an insured, the incurred claim cost above \$1,000, prior to reimbursement, shall be reduced by that percentage. The net incurred cost after such reduction shall be used in any dividend calculation, retrospective rating evaluation or experience rating computation, retroactively if necessary, and shall be reported at that net incurred cost to the rating organization. Any subsequent re-evaluation of the claims reserve requirements under the rules of the Unit Statistical Plan Manual shall be similarly reduced by the percentage of reimbursement.

(2) The paying agency "eligible for" or receiving reimbursement from the Workers with Disabilities Program, shall report the subject claims in such method and manner as the insurance commissioner shall require. Notwithstanding the reporting requirements of the Insurance Commissioner and an authorized rating organization, the paying agency must be able to document that such reimbursed costs are not and will not be included in data reported that will affect the rates and/or dividend eligibility.

(3) If compensation reported to the appropriate rating organization subsequently becomes eligible for reimbursement from the Workers with Disabilities Program, the insured paying agency shall immediately file a "re-evaluation of losses" report, pursuant to the Insurance Commissioner's rules, with a rating organization licensed by the Insurance Commissioner.

(4) If compensation used by the division for experience rating purposes becomes eligible for reimbursement from the Workers with Disabilities Program, the self-insured paying agency may file a request for re-evaluation of experience rating modification(s) with the division. Any necessary calculation(s) will be made, retroactively if necessary, when the annual experience rating modification is calculated.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)

Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08

436-040-0070 Settlements

(1) Any settlement of the claim by the parties is not eligible for reimbursement from the Workers with Disabilities Program unless made with the prior written approval of the division.

(2) Requests for written approval of proposed settlements should include:

- (a) A copy of the proposed settlement;
- (b) Correspondence between the paying agency and the claimant or claimant's representative which establishes the

basis for settlement or a statement from the paying agency of how the amount of the settlement was calculated;

(c) Additional medical reports not available at the time of the determination; and

(d) Other material which would support the proposed settlement as an appropriate manner to handle the claim.

(3) The paying agency shall submit settlements to the division in the format prescribed by the director.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)

Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08

436-040-0080 Third Party Recoveries

(1) If a third party recovery is made prior to a claim qualifying for Workers with Disabilities Program relief, compensation recovered shall be credited against the compensation of the claim prior to any request for reimbursement.

(2) The Workers with Disabilities Program shall be a party to any third party recovery on a claim if payment from the program has been made prior to the third party recovery as provided in ORS 656.591 and ORS 656.593(1)(c).

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)

Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08

436-040-0090 Assessment of Civil Penalties

The director, through the division and pursuant to ORS 656.745, may assess a civil penalty against an insurer. When the division imposes a penalty under this section, the order shall be issued in accordance with ORS 656.447, ORS 656.704 and the contested case provisions of the Administrative Procedures Act (ORS Chapter 183).

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.628

Hist.: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08

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**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 045
REOPENED CLAIMS PROGRAM**

Effective July 1, 2008

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436-045-0001 Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.625 and ORS 656.726.

Stat. Auth.: ORS 656.625 and ORS 656.726; Stats. Implemented: ORS 656.625
Hist.: Filed 12/18/87 as WCD Admin. Order 8-1987, eff. 1/1/88.

436-045-0002 Purpose

The purpose of these rules is to establish guidelines for administering disbursements made from the Reopened Claims Program established to reimburse compensation paid as a result of awards made by the Board or voluntary claim reopenings pursuant to ORS 656.278.

Stat. Auth.: ORS 656.625 and ORS 656.726
Stats. Implemented: ORS 656.625 & 656.726
Hist.: Amended 12/6/01 as WCD Admin. Order 01-062, eff. 1/1/02

436-045-0003 Applicability of Rules

(1) These rules are effective July 1, 2008, and apply to all requests for reimbursement from the Reopened Claims Program.

(2) These rules apply to all awards ordered on claims opened by the Board under ORS 656.278 on or after January 1, 1988 and all voluntary claim reopenings on or after January 1, 2002.

(3) These rules carry out the provisions of ORS 656.625.

(4) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.625; Stats. Implemented: ORS 656.236, 656.289, & 656.625
Hist.: Amended 6/12/08 as WCD Admin. Order 08-056, eff. 7/1/08

436-045-0005 Definitions

As used in OAR 436-045-0001 through 436-045-0030 unless the context requires otherwise:

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

(2) **"Compensation"** includes all benefits payable as a result of any order or award made by the Board or voluntary claim reopening pursuant to ORS 656.278.

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

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

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

(6) **"Disposition"** or **"claim disposition"** means the written agreement executed by all parties in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794, except for medical services, in an accepted claim.

(7) **"Hearings Division"** means the Hearings Division of the Workers' Compensation Board.

(8) **"Paying Agency"** means the insurer, self-insured employer, self-insured employer group or designated representative of the self-insured employer/group, responsible for paying compensation for a compensable injury.

(9) **"Reopened Claims Program"** and **"Program"** means the program established pursuant to ORS 656.625.

(10) **"Voluntary Claim Reopening"** means any claim reopened by the insurer or self-insured employer to provide benefits or to grant additional medical or hospital care to the claimant pursuant to ORS 656.278.

Stat. Auth.: ORS 656.726; Stats. Implemented: ORS 656.726
Hist.: Amended 12/6/01 as WCD Admin. Order 01-062, eff. 1/1/02

436-045-0006 Administration of Rules

Any orders issued by the divisions in carrying out the director's authority to enforce ORS Chapter 656 and these rules are considered orders of the director.

Stat. Auth.: ORS 656.704 & 656.726; Stats. Implemented: ORS 656.704 & 656.726
Hist.: Amended 12/4/97 as WCD Admin. Order 97-061, eff. 1/1/98

436-045-0008 Administrative Review

(1) Any party as defined by ORS 656.005 aggrieved by a proposed order or proposed assessment of civil penalty of the director or division issued pursuant to ORS 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

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

(b) The request for hearing must be filed with the Administrator of the Workers' Compensation Division by the aggrieved person within 60 days after the mailing of the proposed order or assessment. No hearing shall be granted unless the request is mailed or delivered to the administrator within 60 days after the mailing of the proposed order or assessment.

(2) Under ORS 656.704(2), any party that disagrees with an action or order of the director under these rules, other than as described in section (1), may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within

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30 days of the mailing date of the order or notice of action.
OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 656.704, 656.726(4), 656.745; Stats. Implemented: ORS 656.236, 656.289, 656.625, 656.704, OL 2005 ch 26, 656.726(8), 656.740, 656.745
Hist.: Amended 11/1/07 as WCD Admin. Order 07-062, eff. 1/1/08
SMC (repeal of ORS 656.750)—ORS 183.335(7), filed and effective 6/18/24

436-045-0010 Criteria for Eligibility

(1) In order to qualify for reimbursement from the Reopened Claims Program there must be:

(a) An order or award issued by the Board upon its own motion pursuant to ORS 656.278 and as provided by OAR Chapter 438, Division 12 or a voluntary claim reopening; and

(b) Verifiable compensation paid in accordance with the order or award issued by the Board or voluntary claim reopening, including permanent disability awarded as a result of a reopening due to a new or omitted medical condition pursuant to ORS 656.278(1)(b).

(2) Notwithstanding paragraph (1)(b) of this rule, reimbursement may be made from the Program for reasonable overpayments of temporary disability. Reasonable overpayments are those made from the date a worker becomes medically stationary, returns to work or is released to work until the insurer is notified or should have known of the status change.

(3) Costs for claims to subject workers of an employer who is in a noncomplying status as defined in ORS 656.052 are not eligible for reimbursement from the Program but remains a cost recoverable from the employer as provided by ORS 656.054(2).

Stat. Auth.: ORS 656.625
Stats. Implemented: ORS 656.236, ORS 656.289 & 656.625
Hist.: Amended 12/6/01 as WCD Admin. Order 01-062, eff. 1/1/02
Statutory minor correction – ORS 183.335(7) (WCD 10-2021), filed and effective 10/8/21

436-045-0020 Limitation of Program

(1) Reimbursement shall be limited to the monies available in the Workers' Benefit Fund.

(2) In the event of insufficient funds in the Workers' Benefit Fund, the director shall have final authority to determine an equitable distribution which will proportionately distribute the available funds among the claims having qualified for reimbursement under the Program.

Stat. Auth.: ORS 656.625
Stats. Implemented: ORS 656.625
Hist.: Amended 12/4/97 as WCD Admin. Order 97-061, eff. 1/1/98

436-045-0025 Dispositions

(1) In order for a disposition of a claim by the parties to be considered for reimbursement eligibility under the Reopened Claims Program, it must be submitted to the director during the period of time in which the claim remains open under the Board's Own Motion or voluntary claim reopening.

(2) Dispositions submitted in accordance with (1) are not eligible to receive reimbursement from the Reopened Claims Program unless made with the prior written approval of the director.

(3) Requests for written approval of proposed dispositions shall include:

(a) A copy of the proposed disposition which specifies the amount of the proposed contribution to be made from the Reopened Claims Program;

(b) A statement from the insurer indicating how the amount of the contribution was calculated;

(c) Any other information as required by the director.

(4) The director will not approve the disposition for reimbursement if the proposed contribution from the Program exceeds a reasonable projection of that claim's future liability to the Program under that Board's Own Motion reopening or voluntary claim reopening.

Stat. Auth.: ORS 656.236, 656.289, & 656.625
Stats. Implemented: ORS 656.236, 656.289 & 656.625
Hist.: Amended 12/6/01 as WCD Admin. Order 01-062, eff. 1/1/02

436-045-0030 Reimbursement

(1) Reimbursement shall be made by Compliance quarterly after receipt and approval of documentation of compensation paid by the paying agent.

(2) The director, by bulletin, shall prescribe the form and format for requesting reimbursement from the Program. Documentation to support the reimbursement request shall include but not be limited to:

(a) Net temporary disability compensation paid, net permanent disability paid, and net medical compensation paid for dates of injury prior to January 1, 1966. For purposes of this section, "net" compensation paid means the total compensation paid less any recoveries, including but not limited to, third party recovery, Retroactive Program reimbursement, and Workers with Disabilities Program reimbursement.

(b) Payment certification statement.

(c) Any other information deemed necessary by the director.

(3) Periodically Compliance shall audit the physical file of the paying agent to validate the amount reimbursed and to verify that the closing report is correct. Reimbursement shall not be approved if, upon such audit, it is found:

(a) Payments were not authorized in the Board's Own Motion order or voluntary claim reopening; or

(b) Payments of temporary disability compensation were made for periods of time during which the worker did not qualify as a "worker" pursuant to ORS 656.005(28); or

(c) Compensation has been paid as a result of untimely, inaccurate, or improper claims processing; or

(d) The separate payments of compensation have not been documented, as required under generally accepted accounting procedures; or

(e) Medical payments for claims with injury dates prior to January 1, 1966 are in excess of what should have been paid if paid in accordance with OAR 436-009-0030 and properly audited as required by OAR 436-009-0020; or

(f) Permanent disability payments were made in claims reopened for other than a new medical or omitted condition.

Stat. Auth.: ORS 656.625; Stats. Implemented: ORS 656.625
Hist.: Amended 11/1/07 as WCD Admin. Order 07-062, eff. 1/1/08

**OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
EMPLOYER/INSURER COVERAGE RESPONSIBILITY**

**Administrative
Order No.
22-065**

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CHAPTER 436, DIVISION 050**

EMPLOYER/INSURER COVERAGE RESPONSIBILITY

Effective Jan. 1, 2023

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Note:

Worker leasing rules have been relocated to OAR 436-180.

GENERAL PROVISIONS

436-050-0003 Purpose and Applicability

(1) Purpose.

These rules carry out the workers' compensation law related to employers' and insurers' responsibilities to cover subject workers for compensable injuries and illnesses.

(2) Applicability.

(a) These rules apply to employers, self-insured employers, and insurers.

(b) The requirements of OAR 436-050-0165, 436-050-0170, 436-050-0175, 436-050-0180, 436-050-0190, 436-050-0200, 436-050-0205, 436-050-0210 and 436-050-0220 apply to both self-insured employers and self-insured employer groups. References in those rules to "employer" include employer groups, and references to "self-insured employer" include self-insured employer groups.

(c) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS chapter 656

Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0005 Definitions

Unless a term is defined elsewhere in these rules, the definitions of ORS chapter 656 are incorporated by reference and made a part of these rules. For the purpose of these rules, unless the context requires otherwise:

(1) **"Assigned claims agent"** means an entity selected by the director to process the claims of a noncomplying employer under ORS 656.054.

(2) **"Audited financial statement"** means a financial statement audited by an outside accounting firm.

(3) **"Board"** means the Workers' Compensation Board and includes its Hearings Division.

(4) **"Cancel"** or **"cancellation,"** in relation to an insurance policy, means ending the policy at a date before its expiration date.

(5) **"Claims processing location"** means a place of business maintained or operated by an insurer, self-insured employer, self-insured employer group, or service company to process claims and make records available. "Claims processing location" does not include a post office box, commercial mail receiving agency, virtual office, or the place of residence of an employee of the insurer, self-insured employer, self-insured employer group, or service company.

(6) **"Days"** means calendar days unless otherwise specified.

(7) **"Default"** means failure of an employer, insurer, or self-insured employer to pay the moneys due to the director under ORS 656.506, 656.612, and 656.614 at such intervals as the director directs.

(8) **"Director"** means the director of the Department of Consumer and Business Services or the director's designee.

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

(10) **"Governmental subdivision"** means a city, county, special district as defined in ORS 198.010, intergovernmental agency created under ORS 225.050, school district as defined in ORS 255.005, public housing authority created under ORS chapter 456, or regional council of governments created under ORS chapter 190.

(11) **"Insurer"** means the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon.

(12) **"Nonrenewal"** means the insurer's decision not to renew a policy at its expiration date.

(13) **"Person"** means an individual, partnership, corporation, joint venture, limited liability company, association, government agency, sole proprietorship, or other business entity allowed to do business in the State of Oregon.

(14) **"Premium"** means the monetary consideration for an insurance policy.

(15) **"Premium assessments"** means moneys due the director under ORS 656.612 and 656.614.

(16) **"Principal"** means the entity whose liability is secured by a surety bond.

(17) **"Process claims"** means the determination of compensability and management of workers' compensation claims by an Oregon certified claims examiner.

(18) **"Proof of coverage"** has the meaning provided under OAR 436-162-0005.

(19) **"Reinstatement"** means the continuation or reestablishing of workers' compensation insurance coverage under a workers' compensation insurance policy that was previously canceled.

(20) **"Renewal"** or **"renew"** means the issuance of a policy succeeding a previously issued policy or the issuance of a certificate or notice extending the terms of an existing policy for a specified period beyond its expiration date.

(21) **"Self-insured employer"** means an employer certified under ORS 656.430 as having met the qualifications of a self-insured employer under ORS 656.407.

(22) **"Self-insured employer group"** means five or more employers certified under ORS 656.430 as having met the qualifications of a self-insured employer under ORS 656.407.

(23) **"Service company"** means the contracted agent for an insurer, self-insured employer, or self-insured employer group authorized to process claims and make payment of compensation on behalf of the insurer, self-insured employer, or self-insured employer group.

(24) **"State"** means the state of Oregon.

(25) **"Written"** means information communicated in writing, and includes electronic records.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.726(4)

Hist: Amended 12/13/21 as Admin. Order 21-055, eff. 1/1/22

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436-050-0008 Requests for Hearings or Administrative Review

(1) Request for hearing on an action concerning a worker's right to compensation.

Any party, or assigned claims agent, that disagrees with an action taken under these rules that concerns a worker's right to compensation, or the amount of compensation due, may request a hearing by the board under ORS chapter 656 and OAR chapter 438.

(2) Request for hearing on proposed sanctions or civil penalties.

Any party, or assigned claims agent, that disagrees with a proposed order, or proposed assessment of civil penalty, of the director issued under ORS 656.254, 656.735, or 656.745 may request a hearing by the board. To request a hearing, the party or assigned claims agent must:

(a) Mail or deliver a written request to the division within 60 days of the mailing date of the proposed order or assessment; and

(b) Specify, in the request, the reasons why the party or assigned claims agent disagrees with the proposed order or assessment.

(3) Request for administrative review.

Any party, or assigned claims agent, that disagrees with an action taken under these rules other than as described in section (1) of this rule may request the director to conduct an administrative review of the action.

(a) To request administrative review, the party or assigned claims agent must:

(A) Mail or deliver a written request for review to the division within 90 days of the contested action; and

(B) Specify, in the request, the reasons why the party or assigned claims agent disagrees with the action.

(b) Requests mailed more than 90 days after the contested action may be considered if the director determines there was good cause for delay, or that substantial injustice may otherwise result.

(4) Request for hearing on an action not concerning a worker's right to compensation.

Any party, or assigned claims agent, that disagrees with an action or order of the director under these rules other than as described in section (1) or (2) of this rule may request a hearing by filing a request under OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Statutory authority: ORS 656.704 and 656.726(4)

Statutes implemented: ORS 656.254, 656.704, 656.735, 656.740, 656.745, and 656.750

Hist: Amended 12/17/19 as Admin. Order 19-057, eff. 1/1/20

SMC (repeal of ORS 656.750)— ORS 183.335(7), filed and effective 6/18/24

436-050-0015 Suspension and Revocation of Authorization to Issue Workers' Compensation Insurance Policies

(1) General.

The director may suspend or revoke an insurer's authorization to issue or renew workers' compensation insurance policies upon a determination that:

(a) The insurer has failed to comply with its obligations under any workers' compensation policy; or

(b) The insurer has failed to comply with ORS chapter 656, OAR chapter 436, or the orders of the director.

(2) Show-cause hearings.

The director will not suspend or revoke an insurer's authorization to issue or renew workers' compensation insurance policies until the insurer has been given notice and the opportunity to be heard through an informal show-cause hearing with the director.

(a) During the show-cause hearing, the insurer will be provided an opportunity to:

(A) Present evidence regarding any proposed orders by the director to suspend or revoke the insurer's authorization to issue or renew workers' compensation insurance policies; and

(B) Give reason why the insurer should be permitted to continue to issue and renew workers' compensation insurance policies.

(b) Following the show-cause hearing, the director may rescind a proposed order of suspension or revocation if the insurer establishes to the director's satisfaction its ability and commitment to comply with ORS chapter 656 and OAR chapter 436.

(3) Suspension of authorization to issue workers' compensation insurance policies.

If the director suspends an insurer's authorization to issue workers' compensation insurance policies:

(a) The suspension may be in effect for a period of up to 18 months;

(b) The suspended insurer may continue to serve existing accounts and renew any existing policy, unless there is a cancellation or nonrenewal of the policy during the period of suspension; and

(c) The director may audit the performance of the insurer during the period of suspension, and:

(A) If the insurer is in compliance, the director may lift the suspension; or

(B) If the insurer is not in compliance, and the suspension has been in effect for at least 12 months, the director may revoke the insurer's authorization to renew or issue workers' compensation insurance policies.

(4) Revocation of authorization to issue workers' compensation insurance policies.

If the director revokes an insurer's authorization to issue or renew workers' compensation insurance policies:

(a) The insurer may serve an existing account only until the policy is canceled or until the next renewal date, whichever first occurs; and

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(b) The insurer may petition the director to restore the insurer's authorization by submitting a plan demonstrating its ability and commitment to comply with ORS chapter 656, OAR chapter 436, and the orders of the director.

(5) Appeal and revision of orders of suspension or revocation.

Any proposed and final orders of suspension or revocation issued under this rule is a preliminary order subject to revision by the director, and may be appealed under OAR 436-050-0008.

Statutory authority: ORS 656.704 and 656.726(4)
Statutes implemented: ORS 656.254, 656.704, 656.735, 656.740, and 656.745
Hist: Amended 12/17/19 as Admin. Order 19-057, eff. 1/1/20

436-050-0025 Service of the Notice of Civil Penalty Orders

When the director issues a civil penalty order, it will be served by certified mail, return receipt requested, or in any other manner provided by Oregon Rules of Civil Procedure (7)(D) available at:

https://www.oregonlegislature.gov/bills_laws/Pages/orcp.aspx.
Proof of service may include a hard copy signed receipt or electronic verification.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.704, 656.726, and 656.740
Hist: Amended 11/28/16 as WCD Admin. Order 16-054, eff. 1/1/17

COVERAGE

436-050-0040 Responsibility for Providing Coverage When a Contract Is Awarded

(1) If a person, including a person that is a sole proprietorship, that is responsible to provide coverage for an individual performing labor under ORS 656.029, fails to comply with ORS 656.017, that person is considered a noncomplying employer. As used in this section, "sole proprietorship" means a business entity or individual who performs labor without the assistance of others.

(2) As used in ORS 656.029, "the performance of labor where such labor is a normal and customary part or process of the person's trade or business" includes the day-to-day activities or operations which are necessary to successfully carry out the business or trade.

(3) A person contracting to pay remuneration for professional real estate activity as defined in ORS chapter 696, to a qualified real estate broker as defined in ORS 316.209, is not an employer of the qualified real estate broker, and is not required to provide coverage under ORS 656.017.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.029 and 656.037
Hist: Amended 12/13/21 as Admin. Order 21-055, eff. 1/1/22

436-050-0045 Nonsubject Workers

For the purposes of clarifying terms used in ORS 656.027:

(1) "Casual" refers only to employments where the work in any 30-day period, without regard to the number of workers

employed, involves a total labor cost lower than the dollar amount published in Bulletin 387.

(2) "**Home health worker**" does not include a worker employed by a home health agency, as defined in ORS 443.014, or in-home care agency, as defined in OAR 333-536-0005.

(3) "**Person performing foster parent or adult foster care duties**" means:

(a) A person performing foster parent duties, including, but not limited to:

(A) Any person certified as a foster parent by the Oregon Department of Human Services under ORS chapter 418; or

(B) Any person employed by a certified foster parent in the operation of a foster home as defined in ORS chapter 418; or

(b) A person performing adult foster care duties, including, but not limited to:

(A) Any person operating an adult foster home licensed under ORS 443.705 to 443.825; or

(B) Any person employed by the operator to perform services that assist the residents of the adult foster home.

(c) "**Adult foster home,**" as used in subsection (b), means any family home or facility, licensed under ORS 443.705 to 443.825, in which room, board, and 24-hour care services are provided, for compensation, to five or fewer adults who are not related to the operator by blood or marriage.

(4) "**Private employment contract**" means a contract under which a worker is directly employed by the owner of the private home. As used in this section, "**owner of the private home**" means:

(a) Any person who occupies and owns, leases, or rents the private home;

(b) Any person related by blood, marriage, or Oregon registered domestic partnership to a person described under subsection (a); or

(c) Any person who, by direction of a person described under subsection (a), or by order of a court, has become responsible for managing the household affairs of that person.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.027
Hist: Amended 12/13/21 as Admin. Order 21-055, eff. 1/1/22

436-050-0050 Corporate Officers, Limited Liability Company Members, Partners; Subjectivity

(1) A corporation, limited liability company, or partnership may elect to provide workers' compensation coverage for otherwise nonsubject workers.

(a) A carrier-insured employer must make the election to the insurer in writing on or before the effective date of the policy. An election remains in effect until a revised election is given to the insurer.

(b) A self-insured employer must file the election with the director.

(2) If an employer that is subject to a maximum number of exempt corporate officers, members, or partners under ORS 656.027 does not file an initial election, or is not in compliance

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with ORS 656.017 and 656.407, then the exempt individuals will be determined in the following order:

- (a) For a corporation:
 - (A) President;
 - (B) Secretary, if any;
 - (C) Vice President, if any;
 - (D) Secretary/Treasurer, if any;
 - (E) Treasurer, if any;
 - (F) All other officers, if any; or
- (b) For a limited liability company or partnership:
 - (A) The member or partner with the largest ownership interest;
 - (B) The member or partner with the next largest ownership interest; and
- (c) If more than one person holds the same office, or more than one member or partner has equal ownership interest, the sequence of those persons will be the same as the chronological order of their birthdays in a calendar year.

(3) Noncomplying corporations, noncomplying limited liability companies, or noncomplying partnerships, regardless of the number of employees, are limited to two exempt officers, members, or partners to be determined in accordance with section (2) of this rule.

(4) For the purposes of clarifying terms used in ORS 656.027:

(a) **"Commercial harvest of timber"** means all commercial activities relating to harvest of timber from a parcel of property including, but not limited to, road building, marking of trees to be cut, timber falling, slash removal, and transportation of timber to the location where it will be processed into lumber or other products;

(b) **"Director"** means a person elected or appointed to a corporation's board of directors in accordance with its articles of incorporation or bylaws; and

(c) **"Substantial ownership"** means a percentage of ownership equal to or greater than the average percentage of ownership of all the owners, or ten percent, whichever is less.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.027, 656.039

Hist: Amended 12/17/19 as Admin. Order 19-057, eff. 1/1/20

436-050-0055 Extraterritorial Coverage

(1) For the purposes of determining whether a worker is temporarily in or out of state under ORS 656.126, the director will use criteria including, but not limited to, the following:

- (a) The extent to which the worker's work within the state is of a temporary duration;
- (b) The intent of the employer regarding the worker's employment status;
- (c) The understanding of the worker regarding the employment status with the employer;
- (d) The permanent location of the employer and its permanent facilities;
- (e) The circumstances and directives surrounding the worker's work assignment;

(f) The state laws and regulations to which the employer is otherwise subject;

(g) The residence of the worker;

(h) The extent to which the employer's work in the state is of a temporary duration, established by a beginning date and expected ending date of the employer's work; and

(i) Other information relevant to the determination.

(2) Within 30 days after coverage of an Oregon employer is effective, the insurer providing the coverage must notify the employer in writing of the provisions of ORS 656.126 and this rule.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.126

Hist: Amended 11/28/16 as WCD Admin. Order 16-054, eff. 1/1/17

INSURERS

436-050-0110 Notice of Insurer's Place of Business in State; Records Insurer Must Maintain

(1) Oregon claims processing location required.

Except as described in section (4) of this rule, every insurer that is authorized to issue workers' compensation policies to Oregon subject employers must establish and maintain at least one designated Oregon claims processing location as required by ORS 731.475, subject to the following:

(a) The insurer must conduct all claims processing activities necessary to meet the requirements of ORS chapter 656 and OAR chapter 436 from its designated claims processing locations, including, but not limited to:

(A) Processing claims;

(B) Making available all records required under OAR 436-050-0120; and

(C) Responding to specific claims processing inquiries;

(b) At the director's request, the insurer must:

(A) Make claims processing locations accessible during regular business hours or other reasonable times to accommodate periodic audits and examination of records; or

(B) Provide the director electronic access to the records to be audited or examined.

(c) The insurer may process claims subject to ORS chapter 656 remotely. As used in this subsection, to **"process claims remotely"** means to process claims outside of an insurer's Oregon claims processing location, including at the place of residence of an employee of the insurer, as directed from the Oregon claims processing location.

(A) The insurer may not process claims at places of business outside of Oregon that are maintained or operated by the insurer or a service company, except as follows:

(i) The insurer may receive claim reports at locations outside of Oregon if claims are forwarded to an Oregon claims processing location for processing; and

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(ii) Payments may be made from outside of Oregon as directed from the Oregon claims processing location.

(B) The director may suspend an insurer's authority to process claims remotely, subject to the following:

(i) The director may suspend an insurer's authority to process claims remotely when:

(I) The director finds the insurer has repeatedly violated ORS chapter 656 or OAR chapter 436; and

(II) The director has reason to believe that the violations are related to the insurer's practice of processing claims remotely.

(ii) The director will not suspend an insurer's authority to process claims remotely until the insurer has been given notice and the opportunity to be heard through a show-cause hearing with the director. During the show-cause hearing, the insurer will be provided an opportunity to:

(I) Present evidence regarding the proposed order to suspend the insurer's authority to process claims remotely; and

(II) Give reason why the insurer should be permitted to continue processing claims remotely.

(iii) If the director suspends an insurer's authority to process claims remotely, the insurer may not process claims remotely for a specified period of time, up to two years.

(iv) The insurer may request the director restore the insurer's authority to process claims remotely by submitting a plan demonstrating its ability and commitment to comply with ORS chapter 656 and OAR chapter 436.

(v) The insurer may request a hearing on an order of suspension issued under this rule under OAR 436-050-0008(4).

(2) Notice of insurer's business in Oregon.

The insurer must give the director notice of its business in Oregon, subject to the following:

(a) The notice must be filed with the director not more than 30 days after the insurer is authorized and starts writing workers' compensation insurance policies for Oregon subject employers;

(b) The notice must include:

(A) The insurer's:

(i) Legal name;

(ii) Federal Employer Identification Number;

(iii) Identification numbers assigned by the National Association of Insurance Commissioners and the National Council on Compensation Insurance; and

(iv) Certificate of Authority number issued by the director;

(B) The insurer's principal place of business, including its street and mailing addresses, telephone number, and a general email address that is monitored on a regular basis, where the director can direct general inquiries;

(C) A primary contact at the insurer's principal place of business, including the contact's name, title, phone number, fax number, and email address;

(D) If the insurer maintains an Oregon claims processing location:

(i) The street and mailing addresses, and telephone number of the claims processing location; and

(ii) The name, title, phone number, fax number, and email address of a primary contact for the claims processing location;

(E) Contact information for:

(i) A designated person or position within the company who will assure payment of penalties and resolution of collections issues; and

(ii) A designated person or position within the company who can respond to workers' compensation policy and proof of coverage filing inquiries;

(F) If the insurer uses more than one Oregon claims processing location, or locations operated by service companies as described in section (4) of this rule:

(i) The name of each service company, if applicable;

(ii) The street and mailing addresses of each claims processing location; and

(iii) The name, title, phone number, and email address of a contact person at each claims processing location; and

(G) Any other information requested by the director;

(c) The information provided under this section must reasonably lead an inquirer to an Oregon certified claims examiner who can respond to inquiries regarding workers' compensation policies, claim filing, claims processing, and claims processing location information within 48 hours, not including weekends or legal holidays; and

(d) The insurer may use [Form 1352](#), "Insurer's notification of business in Oregon," to satisfy the requirement of this section.

(3) Changes in information.

An insurer must notify the director of a change in any of the information required under section (2) of this rule, subject to the following:

(a) The notice must be filed at least 30 days before the effective date of the change; and

(b) The insurer may use [Form 5188](#), "Insurer Contact Update," to satisfy the requirements of this section.

(4) Service companies.

In lieu of, or in addition to, establishing and maintaining its own claims processing locations in Oregon, the insurer may use Oregon claims processing locations operated by service companies to satisfy the requirements of section (1) of this rule. If an insurer elects to use claims processing locations operated by one or more service companies with respect to all or any portion of its business:

(a) Each service company must be incorporated in or authorized to do business in Oregon;

(b) The insurer must provide the director with a copy of the service agreement between the insurer and each service company for approval. The director must approve the service agreement before the service company begins processing the insurer's Oregon claims, regardless of the agreement's effective date. To be approved, the service agreement must:

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(A) Be an agreement for claims processing services between the underwriting insurer and a service company, and must not be between any other third parties;

(B) Identify the insurer by company name, or if the agreement includes multiple insurers related by ownership, by the name of the group if it includes all affiliates;

(C) Identify the service company by name;

(D) Describe the claims processing services to be provided;

(E) Identify the effective date of the agreement;

(F) Identify the termination date of the agreement, if any;

(G) Grant the service company a power of attorney to act for the insurer in workers' compensation coverage and claims proceedings under ORS chapter 656, subject to the following:

(i) The power of attorney must be effective the same date of the service agreement;

(ii) The power of attorney must not be revocable before all claims processing services provided under the service agreement have concluded;

(iii) The power of attorney must be applicable to all claims processed under the agreement, and may not have unspecified limitations; and

(iv) The service agreement must use language that clearly grants power of attorney to the service company, such as the words "power of attorney" or "attorney-in-fact"; and

(H) Contain only those provisions for workers' compensation activities that are allowed in Oregon, subject to the following:

(i) The director may approve an agreement that contains provisions for activities not allowed in Oregon if the agreement or an addendum provides that any services or provisions not allowed under Oregon workers' compensation law will not be applied when processing Oregon claims; and

(ii) The director may require existing agreements that contain provisions for activities not allowed in Oregon to be amended accordingly;

(c) Each service company must notify the director of its business in Oregon, subject to the following:

(A) The notice must include the service company's location, mailing address, telephone number, email address, and any other contact information requested by the director;

(B) The notice must be filed before the insurer begins using a place of business operated by the service company as a claims processing location; and

(C) The service company may use [Form 4929](#), "Service Company's Notification of Business in Oregon," to satisfy the requirements of this subsection; and

(d) The insurer or service company must notify the director of a change in any of the information required under subsection (4)(c) of this rule, subject to the following:

(A) The notice must be filed at least 30 days before the effective date of the change; and

(B) The insurer may use [Form 5215](#), "Service Company Contact Update," to satisfy the requirements of this subsection.

(5) Limit on claims processing locations.

The insurer may not have more than eight Oregon claims processing locations at any time. For the purposes of this section:

(a) Each of the following is considered to be one claims processing location:

(A) Each physical location where the insurer processes claims or maintains records; and

(B) Each physical location where a service company processes the insurer's claims or maintains records; and

(b) If more than one entity, including the insurer or a service company, processes claims at the same physical location, each entity must be counted as a separate claims processing location.

(6) Changes in claims processing locations.

If an insurer intends to change the location where claims are processed or records of claims are stored, the insurer must, at least 10 days before the change is effective:

(a) Provide notice of the change to any worker, the estate of any deceased worker, or any worker's beneficiary, with an open or active claim that will be processed at the new location, subject to the following:

(A) The notice must include contact information for the new claims processing location, including the name and title of a contact person, telephone number, email address, and mailing address; and

(B) The insurer must send a copy of the notice to the worker's attorney, if the worker is represented, and to the worker's attending physician;

(b) Provide notice of the change to the director, subject to the following:

(A) The notice must include:

(i) Contact information for the current claims processing location, including the name of the claims processor, the name and title of a contact person, mailing address, telephone number, and email address;

(ii) Contact information for the new claims processing location, including the name of the claims processor, the name and title of a contact person, street and mailing address, if different, telephone number, and email address;

(iii) The effective date of the transfer; and

(iv) Any other information requested by the director; and

(B) The notice must specify if all or a portion of the insurer's claims will be transferred, and if closed and denied claims will be included. If only a portion of the insurer's claims will be transferred, the notice must include a listing of the claims being transferred that identifies, for each claim:

(i) The underwriting insurer;

(ii) The employer;

(iii) The claimant's name;

(iv) The date of injury; and

(v) The sending processor's claim number; and

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(c) The insurer may use [Form 5042](#), "Claim Move Notice," to satisfy the requirements of this section.

Statutory authority: ORS 731.475 and 656.726(4)

Statutes implemented: ORS 731.475

Hist: Amended 12/13/21 as Admin. Order 21-055, eff. 1/1/22

436-050-0120 Records Insurers Must Maintain; Removal and Disposition

(1) Records insurers must maintain.

Each insurer is required to maintain the following records of Oregon workers' compensation claims, to make the records available at an Oregon claims processing location, and to provide the director access to the records upon request:

(a) Written records used and relied upon in processing each claim;

(b) A written record of all payments made as a result of any claim including documentation of:

(A) The amount of the payment;

(B) The date the payment was issued;

(C) The date the payment was mailed or delivered; and

(D) An explanation of the time period between the date the payment was issued and the date the payment was mailed or delivered, if any;

(c) Written records of the approval or denial of claims for supplemental temporary disability benefits under ORS 656.210(5);

(d) Written records that show its insured employers have complied with ORS 656.017; and

(e) Written records, or copies of records, of claims processed by prior service companies.

(2) Availability of records.

An insurer must make records available by one or more of the following methods:

(a) By making the records electronically accessible from an Oregon claims processing location in real time.

(b) By keeping physical copies of the records at an Oregon claims processing location; or

(c) By archiving physical copies of the records at a location other than an Oregon claims processing location, under the following conditions:

(A) Records of a denied claim may be archived after all appellate procedures have been exhausted and the denial is final by operation of law; and

(B) Records of any claim for a compensable injury, including a denied claim that is found to be compensable, may be archived after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur.

(3) Destruction of claims records.

The insurer may destroy claims records when the insurer can verify that all potential for benefits to the worker or the worker's beneficiaries is gone.

(4) Proof of coverage records insurer must keep in Oregon.

The records relating to proof of coverage that insurers are required to make available in Oregon include:

(a) A written record of each workers' compensation insurance policy and related endorsements, reinstatements, or cancellations issued as required under the workers' compensation law;

(b) Written records of premiums due and premiums collected by the insurer from its insured employers as a result of coverage issued under the workers' compensation law; and

(c) Written records that segregate and show specifically for each employer the amounts due from the employer and all money collected and paid by the insurer for premiums for insurance coverage, premium assessments, and any other moneys due the director or required to be paid to the director.

(5) Disposal of proof of coverage records.

If all payments have been made, proof of coverage records may be disposed of after the later of:

(a) The next examination of the insurer by the Division of Financial Regulation under ORS 731.300; or

(b) January 1 of the year following three calendar years after the cancellation or nonrenewal of the workers' compensation insurance policy.

Statutory authority: ORS 731.475, and 656.726(4)

Statutes implemented: ORS 731.475

Hist: Amended 12/13/21 as Admin. Order 21-055, eff. 1/1/22

SELF-INSURED EMPLOYERS

436-050-0150 Qualifications of a Self-Insured Employer

(1) General qualifications.

To qualify as a self-insured employer, the employer must:

(a) Establish proof that the employer has an adequate staff qualified to process claims;

(b) Establish proof of the financial ability to make certain the prompt payment of all compensation and other payments due under ORS chapter 656;

(c) Obtain excess insurance coverage in the amounts approved by the director; and

(d) Be registered and authorized to do business in this state under ORS chapters 58, 60, 62, 63, 65, 67, 70, and 648, as applicable, or be a municipal or public corporation as defined in ORS 297.405.

(2) Claims processing staff.

The employer must establish proof of an adequate staff qualified to process claims by:

(a) Employing and retaining at each claims processing location at least one claims examiner who is certified under OAR 436-055-0070 to process claims in this state, and who is actually involved in the claims processing function; or

(b) Contracting the services of one or more service companies that employ at each claims processing location in this state at least one claims examiner who is certified under OAR 436-055-

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0070 to process claims in this state, and who is actually involved in processing the self-insured employer's claims.

(3) Proof of financial ability.

Unless exempt under OAR 436-050-0185, the employer must establish proof of financial ability by:

(a) Providing a security deposit that the director determines is acceptable under OAR 436-050-0165, and in an amount as determined under OAR 436-050-0180; and

(b) Demonstrate acceptable financial strength by maintaining a rating equal to "strong" or "moderate" as determined under sections (4) and (5) of this rule.

(4) Financial strength analysis.

The financial reports submitted by the employer under OAR 436-050-0175(1) must contain information sufficient to calculate the financial ratios described in this section. The points awarded for each ratio will be used to determine the employer's financial strength under section (5) of this rule.

(a) For the purposes of calculating the financial ratios under this section:

(A) The face value of a self-insured employer's irrevocable standby letter of credit (ISLOC) used to satisfy the director's requirement for a security deposit may not be included in the employer's reported assets;

(B) Current assets include all assets that may be reasonably expected to be converted into cash, or could become the equivalent of cash, within one year in the normal course of business;

(i) Current assets include, but are not limited to cash, accounts receivable, inventory, and prepaid expenses, and investments, marketable securities, and bonds that mature within one year or may be converted to cash without penalties or fees; and

(ii) Current assets must not include fixed assets, accumulated depreciation, intangible assets, or investments, marketable securities, or bonds with maturity dates of one year or longer;

(C) Current liabilities are debts and obligations expected to be due within the next year;

(i) Examples of current liabilities include accounts payable, notes payable, accrued taxes, and wages and salaries owed to workers;

(ii) Current liabilities must not include debts or claims on assets that will be due a year or more in the future or longer-term liabilities;

(D) Long-term liabilities must include all debts and obligations expected to be due one year or more in the future. Long-term liabilities include any mortgages, loans, bonds, and claims reserve funds not due within one year;

(E) Net assets are total assets less total liabilities. Financial statements and reports may otherwise refer to net assets as net position, adjusted net worth, surplus, owner's equity, or shareholders' equity; and

(F) Net income is the net revenue from sales, interest, or services rendered minus costs, operating expenses, and taxes. Financial statements and reports may otherwise refer to this

component as comprehensive income, net earnings, or net profit;

(b) Except for employers described under subsection (c) of this section, the director will score the financial strength of an employer based on the following ratios:

(A) The current ratio is calculated by dividing current assets by current liabilities. A maximum of six points are possible for the current ratio, to be awarded as follows:

Ratio		Points
At least 2	=	6 points
At least 1.75	=	5 points
At least 1.6	=	4 points
At least 1.4	=	3 points
At least 1.25	=	2 points
At least 1	=	1 points
Less than 1	=	0 points

(B) The debt-to-equity ratio is calculated by dividing long-term liabilities by net assets. A maximum of six points are possible for the debt-to-equity ratio, to be awarded as follows:

Ratio		Points
25% or less	=	6 points
50% or less	=	5 points
70% or less	=	4 points
80% or less	=	3 points
90% or less	=	2 points
100% or less	=	1 points
More than 100%	=	0 points

(C) The return-on-net assets ratio is calculated by dividing net income by net assets. A maximum of six points are possible for the return-on-net-assets ratio, to be awarded as follows:

Ratio		Points
At least 10%	=	6 points
At least 8%	=	5 points
At least 6%	=	4 points
At least 4%	=	3 points
At least 3%	=	2 points
At least 2%	=	1 points
Less than 2%	=	0 points

(c) The director will score the financial strength of an employer that is a municipal corporation as defined in ORS 297.405 that submits a Comprehensive Annual Financial Report, based on the following ratios:

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(A) The current ratio is calculated by dividing current assets by current liabilities. A maximum of six points are possible for the current ratio, to be awarded as follows:

Ratio		Points
At least 2	=	6 points
At least 1.75	=	5 points
At least 1.6	=	4 points
At least 1.4	=	3 points
At least 1.25	=	2 points
At least 1	=	1 points
Less than 1	=	0 points

(B) The debt service ratio is calculated by dividing total debt service by total revenue. A maximum of six points are possible for the debt service ratio, to be awarded as follows:

Ratio		Points
10% or less	=	6 points
12% or less	=	5 points
14% or less	=	4 points
16% or less	=	3 points
18% or less	=	2 points
20% or less	=	1 points
More than 20%	=	0 points

(C) The return-on-net assets ratio is calculated by dividing net income by net assets. A maximum of six points are possible for the return-on-net-assets ratio, to be awarded as follows:

Ratio		Points
At least 5%	=	6 points
At least 4%	=	5 points
At least 3%	=	4 points
At least 2%	=	3 points
At least 1.5%	=	2 points
At least 1%	=	1 points
Less than 1%	=	0 points

(5) Rating of financial strength.

The employer's financial strength will be rated based on the sum of the points awarded for the three ratios under section (4) of this rule.

(a) A sum of 13 to 18 points is equal to a strong rating:

(A) The director will approve initial or continued certification if the employer meets all of the requirements of this rule; and

(B) The employer's security deposit amount will be determined based on OAR 436-050-0180(1) or (3);

(b) A sum of 7 to 12 points is equal to a moderate rating:

(A) The director will approve initial or continued certification if the employer meets all the requirements of this rule; and

(B) The employer's security deposit amount will be determined based on OAR 436-050-0180 (1) and (2), or (3); and

(c) A sum of 0 to 6 points is equal to a weak rating:

(A) The director may not approve the application for initial self-insured employer certification; and

(B) For an existing certified self-insured employer, the director may take one or more actions, including but not limited to:

(i) Providing the employer notice of the director's intent to revoke its self-insurance certification under OAR 436-050-0200 and this rule;

(ii) Increasing the security deposit calculated under OAR 436-050-0180 by an amount based on factors including, but not limited to, the considerations identified in OAR 436-050-0180(4);

(iii) Allowing the amount of the security deposit to be determined based on a certified actuarial study under OAR 436-050-0180(3); or

(iv) Requiring the employer to submit a financial correction plan that demonstrates the employer's ability to improve its rating, in a reasonable time period, without hampering the employer's ability to pay compensation and other amounts due under ORS chapter 656.

(6) Financial strength based on municipal bond ratings.

Notwithstanding section (5) of this rule, a public self-insured employer that provides verifiable evidence of a municipal bond rating of Aa3, AA-, or higher will be considered to have a strong financial strength rating.

Statutory authority: ORS 656.407 and 656.726(4)

Statutes implemented: ORS 656.407

Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0160 Applying for Certification as a Self-Insured Employer

(1) Required information.

An employer applying for certification as a self-insured employer must submit:

(a) A completed [Form 1868](#), "Application for Self-Insurance;"

(b) Proof of an adequate staff qualified to process the employer's claims under OAR 436-050-0150(2);

(c) The employer's audited financial statements or audited annual reports for the last three fiscal or calendar years, subject to the following:

(A) If the audited financial statements of a parent company are provided in place of statements for the employer, the director will not authorize the individual employer to be self-insured under its own program, unless a parental company guarantee can be obtained. Otherwise, it will be necessary for the parent company to be the self-insured employer or to separately insure the employer. In the context of this section, a parent company is a legal entity that owns a majority interest in the employer, or owns a majority interest in another entity or succession of entities that own a majority interest in the employer; or

(B) If audited financial statements are not available at the time of application, the employer may submit certified financial statements in place of audited financial statements or annual reports. However, if the certified financial statements submitted are insufficient to evaluate the employer's financial ability, the

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director may require the employer to submit audited financial statements;

(d) The employer's most recent experience rating modification worksheet and supporting documentation. Applicants with prior Oregon experience who do not submit this data will be assigned a 1.50 experience rating modification pending receipt of the data. All those without prior Oregon experience will be assigned a 1.00 experience rating modification;

(e) The type, retention, and limitation levels of excess workers' compensation insurance the employer is planning to obtain as required by OAR 436-050-0170;

(f) If applicable, a service agreement between the employer and service company that has been signed by both parties that meets the requirements of OAR 436-050-0210. The agreement must:

(A) Be submitted at least 14 days before the desired date of certification, and be approved by the director before the service company begins processing claims, regardless of the effective date established in the agreement; and

(B) Contain the location, mailing address, telephone number, and any other contact information of the service company;

(g) Proof of the employer's ability to provide an acceptable security deposit, including either:

(A) Evidence from a surety bond company admitted to do surety business in this state that they will issue a surety bond for the employer, as Principal, and the Oregon Department of Consumer and Business Services, Workers' Compensation Division, as Obligatee; or

(B) Evidence from a qualified bank that they will issue an irrevocable standby letter of credit for the employer with the Oregon Department of Consumer and Business Services as the beneficiary;

(h) Evidence of an occupational safety and health loss control program in accordance with OAR 437-001 as required by ORS 656.430(10); and

(i) Evidence of:

(A) The employer's authorization to do business in this state under ORS chapters 58, 60, 62, 63, 65, 67, 70, and 648, as applicable; or

(B) The employer's status as a municipal or public corporation as defined in ORS 297.405.

(2) Review of application.

Within 30 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the employer that the request for certification as a self-insured employer is approved or denied.

(a) If the request is denied, the notice will include the reason for denial; or

(b) If the request is approved, the notice will include:

(A) Confirmation of the type and the amount of the security deposit required;

(B) Approval of the type, retention, and limitation levels of the excess insurance required; and

(C) Approval of a service agreement submitted under OAR 436-050-0110, if applicable.

(3) Issuance of certification.

If approved, the self-insurance certification will be issued upon receipt of the security deposit and the appropriate excess insurance binder. The effective date of certification will be the first day of the month following the date the certificate is issued, or a later date specified by the applicant.

Statutory authority: ORS 656.430, and 656.726(4)

Statutes implemented: ORS 656.430

Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0165 Security Deposit Requirements

(1) Adoption of standards.

The director adopts, by reference, the International Standby Practices 1998 (ISP98), ICC Publication No. 590.

(a) This publication may be purchased from the International Chamber of Commerce website at <https://2go.iccwbo.org/>; and

(b) Copies of this publication are available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301.

(2) Required security deposit.

Each self-insured employer is required to provide a security deposit that is acceptable to the director as detailed in [Bulletin 147](#). Under the conditions and requirements of this rule, the director may accept:

(a) An irrevocable standby letter of credit (ISLOC); or

(b) A surety bond.

(3) Irrevocable standby letters of credit.

An ISLOC may be accepted by the director as all or part of the security deposit.

(a) The director may accept the ISLOC under the following conditions:

(A) The ISLOC is issued or confirmed by an Oregon state-chartered bank or a federally chartered bank from which funds will be immediately payable on demand;

(B) Except for federally chartered instrumentalities of the United States operating under the authority of the Farm Credit Act of 1971, as amended, the issuing bank has a long-term certificate of deposit rating of:

(i) "A" or better issued by Moody's Investors Service Inc.; or

(ii) "A" or better issued by S&P Global Ratings;

(C) An ISLOC issued by a bank that does not meet the rating requirement of paragraph (B) at the time of issuance will only be accepted with a confirming ISLOC issued by an Oregon state-chartered bank or federally chartered bank that meets the rating requirement of paragraph (B). The confirming ISLOC must state that the confirming bank is primarily obligated to pay on demand the full amount of the ISLOC regardless of reimbursement from the bank whose ISLOC is being confirmed;

(D) [Form 3640](#), "Irrevocable Standby Letter of Credit," is used for the ISLOC;

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(E) The ISLOC is issued under the legal name or assumed business name of the self-insured employer as registered with the Oregon Secretary of State;

(F) The ISLOC names the State of Oregon, acting by and through the Department of Consumer and Business Services, as its beneficiary;

(G) The ISLOC allows the beneficiary to demand payment immediately if the self-insured employer has:

(i) Defaulted in payment of its workers' compensation liabilities or obligations, or in payments due to the director under ORS chapter 656;

(ii) Filed for bankruptcy;

(iii) Failed to renew the ISLOC or provide acceptable substitute security at least 15 days before the expiration date of the ISLOC; or

(iv) Failed to provide additional or replacement security after being ordered to do so by the director, notwithstanding written notice to the self-insured employer;

(H) The ISLOC states that:

(i) The funds provided by the ISLOC will be available by presentation of the beneficiary's sight draft drawn on the issuing bank, payable within three business days, when accompanied by one of the statements contained in paragraph (G) of this subsection, signed by the director;

(ii) The ISLOC is not subject to any qualifications or conditions by the issuing bank or confirming bank and is each bank's individual obligation, which is in no way contingent upon reimbursement;

(iii) The ISLOC will be automatically extended without amendment for one year from the expiration date or any subsequent expiration date, unless, at least 60 days before the expiration date, the bank gives the director written notice by registered mail or overnight delivery that the bank has elected not to extend the ISLOC for another period;

(iv) If the issuing bank or any confirming bank is closed at the time of expiration of the ISLOC for any reason that would prevent delivery of a demand notice during its normal hours of operation, the ISLOC will be automatically extended for a period of 30 days commencing on the next day of operation;

(v) Payment of any amount under the ISLOC will be made by wire transfer to a department account with the State Treasurer at a designated bank, as instructed in the demand notice;

(vi) All bank charges for the ISLOC will be for the account of the applicant;

(vii) Any amendment to the ISLOC must be approved by the beneficiary before the amendment is effective;

(viii) The funds provided by the ISLOC are not construed to be an asset of the self-insured employer;

(ix) If legal proceedings are initiated by any party with respect to payment of any ISLOC, the proceedings will be subject to the jurisdiction of Oregon courts and application of Oregon law;

(I) The ISLOC conforms to and references the International Standby Practices 1998 (ISP98), ICC Publication No. 590;

(J) The self-insured employer that submits the ISLOC provides an accompanying [Form 3529](#), "Memorandum of Understanding," affirming the employer's agreement to the following:

(i) The ISLOC is provided to the director in place of, or in addition to, a surety bond or other form of security acceptable to the director under this rule;

(ii) The ISLOC will remain in force without amendment unless canceled by the issuing bank as provided in (H)(iii) of this subsection;

(iii) The ISLOC may be replaced with an ISLOC or surety bond of equal amount that is accepted by the director as substitute security, or a policy of paid-up insurance that is accepted by the director in accordance with OAR 436-050-0200(5);

(iv) The director may immediately demand payment under the ISLOC as provided in paragraph (G) of this subsection;

(v) The funds provided from a demand for payment under the ISLOC will be administered as provided in subsection (b) of this section and OAR 436-050-0190(1)(b); and

(vi) If legal proceedings are initiated by any party with respect to payment of any ISLOC, the proceedings will be subject to the jurisdiction of Oregon courts and application of Oregon law.

(b) If the director demands payment under an ISLOC, the funds provided by the ISLOC will be deposited with the State Treasurer in an account separate and distinct from the General Fund.

(c) If a bank's rating falls below the ratings required in (a)(B) of this section subsequent to the issuance of the ISLOC, the self-insured employer must, within 60 days of the publication of the lower rating:

(A) Have the ISLOC confirmed by an Oregon state-chartered bank or a federally chartered bank that has an acceptable rating;

(B) Replace the ISLOC with a security deposit that is accepted by the director in accordance with this rule and that covers all workers' compensation liabilities and obligations that would have been covered by the ISLOC; or

(C) Obtain a policy of paid-up insurance that is accepted by the director in accordance with OAR 436-050-0200(5), if the certification of the self-insured employer has been canceled or revoked.

(4) Surety bonds.

A surety bond may be accepted by the director as all or part of the security deposit.

(a) The director may accept the surety bond under the following conditions:

(A) The surety bond is issued by a surety company authorized under ORS chapter 731 to transact surety business in Oregon;

(B) The surety company or its parent has:

(i) An Insurer Financial Strength Rating of A or better issued by S&P Global Ratings; or

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(ii) A Financial Strength Rating of B+ or better issued by A.M. Best Rating Services, Inc.;

(C) [Form 824](#), "Surety Bond," is used for the surety bond;

(D) The surety bond is issued under the legal name or assumed business name of the self-insured employer as registered with the Oregon Secretary of State;

(E) The surety bond is continuous in form;

(F) The surety bond states that it may only be terminated by the surety company by giving the director and the Principal written notice. The notice must state that the termination will be effective on a date not less than thirty days after the date the notice is received by the director. Termination of a surety bond in no way limits the liability of the surety for defaults of the Principal's liability or obligations under ORS chapter 656 before the effective date of the termination;

(G) The surety bond states that the liability of the surety company may only be discharged in the event that the surety bond is released in writing by the director. The director may release a surety bond when:

(i) The Principal provides substitute security that is accepted by the director in lieu of the surety bond to be released, covering all past, present, existing, and potential liability of the Principal under ORS chapter 656, in an amount required by the director; or

(ii) If the certification of the self-insured employer has been canceled or revoked, the employer obtains a policy of paid-up insurance that is accepted by the director in accordance with OAR 436-050-0200(5).

(H) The surety bond and all surety bond riders are executed by the surety company's attorney-in-fact. The attorney-in-fact's appointment and power of attorney must accompany the surety bond and all riders submitted. The power of attorney must authorize the attorney-in-fact to execute the surety bond in the amount of the penal sum of the bond.

(b) [Form 1810](#), "Surety Bond Rider" must be used for all department-required increases or authorized decreases in the penal sum of the surety bond and all changes to the name of the Principal. The surety bond rider is not effective until it is accepted by the department.

(c) If the surety company is placed in conservatorship, is seized, declares insolvency, or has a current credit rating below the ratings required in (a)(B) of this section, the self-insured employer must, within 30 days of receiving notice from the department:

(A) Replace the surety bond with a security deposit that is accepted by the director in accordance with this rule and that covers all workers' compensation liabilities and obligations that would have been covered by the surety bond; or

(B) Obtain a policy of paid-up insurance that is accepted by the director in accordance with OAR 436-050-0200(5), if the certification of the self-insured employer has been canceled or revoked.

(5) Government securities, certificates of deposit, or time deposit accounts.

Government securities, certificates of deposit, or time deposit accounts will not be accepted as security deposits for certified self-insured employers who must increase their security deposit or for employers whose self-insurance certification was granted after January 1, 2004.

(a) Government securities, certificates of deposit, or time deposit accounts that were accepted by the director as a self-insured employer's or a self-insured employer group's required security deposit before January 1, 2004, may remain as the security deposit until the maturity date of those investments. At that time, the government securities, certificates of deposit, or time deposit accounts pledged to the department as security deposits must be replaced by a surety bond or ISLOC acceptable to the director.

(b) A self-insured employer that has government securities, certificates of deposit, or time deposit accounts as all or part of its security deposit must complete [Form 4023](#), "Security Agreement and Notice to Intermediary," granting the department a security interest in and control over those financial assets.

Statutory authority: ORS 656.430 and 656.726(4)

Statutes implemented: ORS 656.430

Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0170 Excess Insurance Requirements

(1) Excess insurance requirements.

A self-insured employer must have excess workers' compensation insurance coverage appropriate for the employer's potential liability under ORS chapter 656 with an insurer authorized to do business in this state, subject to the following:

(a) Except for endorsements requiring pre-approval by the director under sections (3) and (4) of this rule, the policy providing such coverage and any subsequent endorsements must be filed with the director within 30 days after the effective date of the policy or endorsement;

(b) A self-insured public utility with assets in excess of \$500 million as reflected by the employer's audited financial statement submitted in accordance with OAR 436-050-0160 or 436-050-0175, may obtain the required excess workers' compensation insurance coverage from an eligible surplus lines insurer;

(c) The excess insurance policy must include a provision for reimbursement to the director of all expenses paid by the director on behalf of the self-insured employer under ORS 656.614 and 656.443 as if the director were the insured employer, subject to the policy limitations or amounts and limits of liability to the insured employer;

(d) Coverage must be continuous and remain in effect from the date of certification until the certification is revoked or canceled;

(A) Coverage must be specific on a per-occurrence basis;

(B) Coverage may include aggregate excess insurance; and

(C) Coverage may include a deductible endorsement acceptable to the director under sections (3) and (4) of this rule;

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(e) Excess insurance obtained under this rule does not relieve any self-insured employer from full responsibility for claims processing and the payment of compensation required under ORS chapter 656 and OAR chapter 436. The excess insurance policy may not contain provisions or endorsements that do not comply with Oregon law, including but not limited to, provisions or endorsements that allow the excess insurer to process claims, pay compensation, or change the location where a claim is processed.

(f) A self-insured employer may not transfer claims to any excess insurer or service company acting on behalf of an excess insurer for the processing of the employer's claims, regardless of the types and amounts of excess coverage; and

(g) When an excess insurance policy is canceled by the excess insurer or the employer, a copy of the notice of cancellation must be filed with the director at least 30 days before the effective date of cancellation.

(2) Self-insured retention level for a self-insured employer group.

The self-insured retention level for a self-insured employer group's excess insurance policy must not be less than \$300,000.

(3) Changes in the self-insured retention level.

Changes in the self-insured retention level and policy limits of the excess insurance require prior approval of the director. Proposed changes must be submitted to the director for approval at least 30 days before the effective date of the change. The director may require a reduction in the self-insured retention level or an increase in the policy limits by order. When determining and approving the retention and limitation levels of the excess insurance, the director will consider:

- (a) The employer's financial status;
- (b) The employer's financial strength as determined under OAR 436-050-0150 or 436-050-0260;
- (c) The employer's risk and exposure;
- (d) The employer's claim history; and
- (e) The amount of the employer's required security deposit.

(4) Per-accident deductible endorsements.

Any endorsements addressing a per-accident deductible in excess of a self-insured employer group's retention level must be approved by the director before the effective date of the endorsement, subject to the following:

(a) In determining whether to approve a deductible endorsement, the director will consider the group's retention level, policy limits, and the items listed in section (3) of this rule; and

(b) The director will not approve per-accident deductible endorsements in excess of the retention level that contain language allowing the excess insurer, at its discretion, to limit its obligations under (1)(c) of this rule.

(5) Director's orders to amend excess insurance.

A self-insured employer must comply with an order of the director to reduce the self-insured retention level or increase the

policy limitation or amounts and limits of liability of the excess insurance within 30 days after the order's mailing date.

Statutory authority: ORS 656.430, and 656.726(4)

Statutes implemented: ORS 656.430

Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0175 Annual Reporting Requirements

(1) Annual Financial Report.

Every self-insured employer must file an annual financial report with the director, subject to the following:

(a) The report must include the employer's audited financial statements or annual report with audited financial statement for the just completed fiscal year, and SEC Form 10K, if issued;

(b) The report must be filed within the following time frames:

(A) A self-insured employer that is not a municipal or public corporation as defined in ORS 297.405 must make the filing within 120 days of the end of its fiscal year; or

(B) A self-insured employer that is a municipal or public corporation as defined in ORS 297.405 must make the filing within 180 days of the end of its fiscal year;

(c) If audited financial statements are not available for filing within the time frames of subsection (b), the self-insured employer may file a financial statement that is certified by the employer that the financial statement is true and accurate and presents the employer's financial condition and results of operations as of the date of the statement. The director may require a self-insured employer to submit an audited financial statement if the certified financial statement submitted is insufficient to evaluate the employer's financial status;

(d) The financial statements and reports must include information sufficient to determine the self-insured employer's financial viability under OAR 436-050-0150 or OAR 436-050-0260; and

(e) All financial statements and annual financial reports filed under this section will be retained by the director for a period of at least three years.

(2) Additional requirements for self-insured employer groups.

In addition to the requirements of section (1) of this rule, by March 1 of each year each self-insured employer group must file with the director:

(a) A statement certifying the group meets or exceeds the combined net worth requirement under OAR 436-050-0260(3)(a), as of the date of the statement;

(b) A copy of the fidelity bond furnished to the group by the administrator or a copy of the comprehensive crime policy obtained by the group, in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities. If the group previously filed a copy of a fidelity bond or policy that covers more than one year, and that fidelity bond or policy is still in effect, the group may include a statement in their annual report referring the director to the copy on file in place of providing an additional copy; and

(c) If the self-insured employer group consists of private employer members:

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(A) A statement certifying that each member of the group meets the individual net worth requirement under OAR 436-050-0260(3)(b), as of the member's most recent fiscal year end; and

(B) A list of the group's current board members and their professional affiliations.

(3) Claim loss data reporting.

The self-insured employer must report claim loss data to the director by March 1 of each year for the purposes of experience rating modification, retrospective rating calculations, and determining deposits. [Bulletin 209](#) provides guidelines for self-insured employers and their authorized representatives to use in submitting the required data. The report must be certified to be true and accurate by an authorized representative of the employer, and must include:

(a) A report of losses for each year in the experience rating period. The report must cover all claims incurred during the reporting period and must be valued as of January 1 of the current year, and must include:

(A) Contract medical expenses;

(B) Total medical reimbursement amount;

(C) The number of claims for which medical reimbursement is claimed; and

(D) Separate lists including all claims with total incurred losses above and below the National Council on Compensation Insurance split point published in [Bulletin 209](#). The lists must include:

(i) The worker's name, listed in alphabetical order;

(ii) The date of injury;

(iii) The claim number;

(iv) The total amount paid;

(v) The medical reimbursement amount claimed, if applicable;

(vi) Outstanding reserves; and

(vii) Total incurred losses;

(b) A report of losses covering the self-insured employer's non-experience period. The report must list all open claims and must be valued as of January 1 of the current year, and must include:

(A) The worker's name, listed in alphabetical order;

(B) The date of injury;

(C) The claim number;

(D) The total amount paid;

(E) Outstanding reserves; and

(F) Total incurred losses;

(c) Identification of claims involving:

(A) Catastrophes;

(B) The Workers with Disabilities Program;

(C) Permanent total disability;

(D) Fatal benefits;

(E) Third party recoveries; and

(F) Total incurred losses that exceed, or are expected to exceed, the self-insured retention level of the self-insured employer's excess insurance policy;

(d) If the self-insured employer is a city, county, or qualified self-insured employer group that is exempted from the security deposit requirements under ORS 656.407(3) and OAR 436-050-0185:

(A) The procedures, methods, and criteria used in the process of determining the amount of their actuarially sound workers' compensation loss fund, including procedures for determining the amount for injuries incurred but not reported; and

(B) Upon the director's request, an actuarial study that demonstrates its loss reserve account is actuarially sound and adequately funded under OAR 436-050-0185(2)(a)(D).

(4) Director's requests for additional information.

The director may require a self-insured employer to provide additional information, or submit financial statements, reports, or claims loss data more frequently.

(a) The director may require additional information or financial statements for reasons including, but not limited to:

(A) Changes in the financial status or viability of a self-insured employer or group; and

(B) Changes in the net worth, group membership, or private employer group's board membership of a self-insured employer group.

(b) The director may require a self-insured employer to submit additional claim loss data if the nature of the employer's business has changed since the last annual loss report for reasons including, but not limited to, mergers or acquisitions, changes in employment level, nature of employment, or incurred claims costs.

(5) Sanctions for failure to comply with this rule.

If a self-insured employer does not comply with the requirements of this rule, the director may:

(a) Require the self-insured employer to increase its deposit and premium assessments by 25 percent;

(b) Conduct an audit to obtain the necessary loss information at the self-insured employer's expense;

(c) Assess civil penalties of up to \$250 per day that the information is not provided beyond the deadline; or

(d) Revoke the employer's self-insurance certification under OAR 436-050-0200 or OAR 436-050-0340.

(6) Claims reserve audits.

To ensure each self-insured employer's claims are valued appropriately for use in deposit, experience rating, and retrospective rating calculations, the director will perform routine claims reserve audits.

(a) The values determined at audit will be used to calculate the self-insured employer's security deposit, experience rating factor, and retrospective rating adjustment.

(b) If there is a 10 percent or greater difference between the values determined by the director at audit and the values that

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were reported by the self-insured employer, the director may assess civil penalties against the employer.

Statutory authority: ORS 656.407, 656.430, and 656.726(4)
Statutes implemented: ORS 656.407 and 656.430
Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0180 Determination of Amount of Self-Insured Employer's Deposit; Effective Date of Order to Increase Deposit

(1) Minimum security deposit.

Except for self-insured cities, counties, or qualified self-insured employer groups who are exempted under ORS 656.407(3) and OAR 436-050-0185, each self-insured employer is required to maintain a security deposit with the director in an amount determined by the director, subject to the following:

(a) The deposit will not be less than the greater of:

(A) \$100,000;

(B) Future claim liability, including losses incurred but not reported (IBNR), a claims processing administrative cost, and the anticipated assessments payable to the director for the employer's next fiscal year; or

(C) The annual incurred losses for the self-insured employer's last fiscal year, including IBNR, a claims processing administrative cost, and anticipated assessments payable to the director for the employer's next fiscal year;

(b) If the employer is applying for self-insurance, the amount of the initial deposit will not be less than the greater of:

(A) The anticipated assessments payable to the director for the employer's next fiscal year, plus an amount equal to 65 percent of the annual premium the employer would pay if carrier-insured using the applicable occupational base rate premium, as such rate is applied to the anticipated payroll of the employer's Oregon operations for the employer's next fiscal year;

(B) \$300,000 plus \$30,000 additional for each \$100,000 the employer's net worth is below \$2 million; or

(C) The amount of the approved self-insured retention level for the employer's excess workers' compensation insurance;

(c) Assessments payable to the director referred to in this section include moneys and assessments due under ORS 656.506, 656.612, and 656.614;

(d) Claims processing administrative costs will be determined by developing a percentage rate to be applied against the employer's unpaid losses;

(A) The rate will be based on the information contained in Schedule P, Part ID (Workers' Compensation) of the Annual Statement for the previous calendar year as reported to the Insurance Commissioner by SAIF Corporation and the 20 private insurers who had the highest earned premium reported for the preceding calendar year; and

(B) The rate will be computed annually to be effective for the subsequent fiscal year. The rate will be 105 percent of the median of ratios determined as follows for each of these insurers:

(i) "Loss expenses unpaid" for losses incurred in the latest eight years, divided by

(ii) "Losses unpaid" for losses incurred in the latest eight years; and

(e) Under this section, "Incurred but not reported" (IBNR) will be calculated by applying a loss development factor determined by the director against the employer's incurred losses.

(2) Financial strength adjustment.

If the self-insured employer received a financial strength rating equal to "moderate" under OAR 436-050-0150(5) or OAR 436-050-0260(12), the amount of the deposit determined under section (1) will be increased by the following percentage factors:

(a) 12 total combined points = no change in calculated deposit;

(b) 11 total combined points = no change in calculated deposit;

(c) 10 total combined points = 5%;

(d) 9 total combined points = 10%;

(e) 8 total combined points = 15%; or

(f) 7 total combined points = 20%.

(3) Certified actuarial study.

A self-insured employer may request for its security deposit amount to be determined based on a recommended loss reserve level established by a certified actuarial study in place of the calculations under sections (1) and (2) of this rule. The director may base a self-insured employer's security deposit amount on a certified actuarial study under the following conditions:

(a) The actuarial study must be certified by an actuary who is a member in good standing of the American Academy of Actuaries;

(b) The actuarial study must be submitted to the director within seven days after the date of the director's notice establishing the security deposit amount calculated under sections (1) and (2) of this rule;

(c) The actuarial study must include an estimate or range of estimates of future claim liability and state what provisions for adverse claim development are included in these estimates;

(d) The actuarial study must identify the confidence levels associated with the recommended loss reserve level or loss reserve range;

(e) The actuarial study must include a statement of future claim liability, including the employer's incurred but not reported (IBNR) losses;

(f) Subject to the minimum requirements of ORS 656.407 and this rule, upon the director's review and acceptance of the study, the amount of the security deposit will be based on:

(A) The actuarially sound recommended loss reserve level if a single estimate is provided; or

(B) The 75% confidence level estimate, if an actuarially sound loss reserve range is provided; and

(g) If there is probable cause to believe the recommended loss reserve level or range is not actuarially sound, the director will determine the security deposit based on the calculations under sections (1) and (2) of this rule. Probable cause includes, but is not limited to:

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(A) The actuarial study not containing a statement by the actuary that the recommended loss reserve level or range is actuarially sound;

(B) The actuarial study containing a disclaimer regarding the actuary's qualifications or ability to determine the adequacy of the loss reserve level for current or future liabilities; or

(C) The recommended loss reserve level or entire recommended loss reserve range being less than the 75 percent confidence level estimate established in the actuarial study.

(4) Additional factors for security deposit amount.

In determining the amount of the self-insured employer's security deposit based on the calculations under sections (1) and (2) of this rule, or a certified actuarial study under section (3) of this rule, the director will take the following factors into consideration:

(a) The financial ability of the employer to pay compensation and other payments due;

(b) The employer's probable continuity of operation;

(c) The employer's financial viability, as determined by the director under OAR 436-050-0150 or 436-050-0260;

(d) Retention and limitation levels of the employer's excess insurance in relation to the employer's financial status;

(e) Changes in the employer's business including, but not limited to, mergers or acquisitions, changes in employment level, nature of employment, incurred claims costs, or material growth in self-insured exposure;

(f) The balance of the Self-Insured Employer Adjustment Reserve or the Self-Insured Employer Group Adjustment Reserve; and

(g) The employer's credit rating issued by a nationally recognized statistical ratings organization;

(5) Time frame for compliance.

A self-insured employer must comply with an order of the director to the self-insured employer to increase the amount of its deposit within 30 days of the order. Failure to comply with this rule may result in the assessment of civil penalties, revocation of the employer's self-insurance certification, or both.

Statutory authority: ORS 656.407, and 656.726(4)
Statutes implemented: ORS 656.407
Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0185 Qualifications for Deposit Exemption for Self-Insured Cities, Counties, and Qualified Self-Insured Employer Groups, Application Procedures, Conditions and Requirements, Revocation and Requalification

(1) Requirements to qualify for deposit exemption.

A self-insured city, county, or self-insured employer group that is a municipal or public corporation under ORS 297.405 may apply to be exempt from the security deposit requirements of ORS 656.407(2) and OAR 436-050-0150, if it meets the following requirements:

(a) The city, county, or qualified self-insured employer group must be in compliance with ORS 656.407(2) and OAR 436-

050-0180 as an independently self-insured employer or self-insured employer group for the three consecutive years immediately before applying for the exemption; and

(b) The city, county, or qualified self-insured employer group must have in effect a workers' compensation loss reserve account that is actuarially sound and that is adequately funded as determined by the annual audit under ORS 297.405 to 297.740 to pay all compensation to injured workers and amounts due the director under ORS chapter 656. The workers' compensation loss reserve account must also be dedicated to and expended only for payment of compensation and amounts due the director by the city or county under ORS chapter 656.

(2) Application for security deposit exemption.

To apply for exemption from ORS 656.407(2), the city, county, or qualified self-insured employer group must submit a written application to the director no later than 45 days before the date the exemption is desired to become effective.

(a) The application must include the following supporting documentation for review and approval:

(A) A copy of the city's, county's, or qualified self-insured employer group's most recent annual audit as filed with the Secretary of State under ORS 297.405 to 297.740 that identifies the actuarially sound funded amount in the dedicated workers' compensation loss reserve if not previously filed as required by OAR 436-050-0175(1);

(B) A copy of the city's, county's, or qualified self-insured employer group's current fiscal year's approved budget documents for internal service funds that state the budgeted amount for the funded workers' compensation loss reserve account;

(C) A resolution or ordinance passed by the city's, county's, or qualified self-insured employer group's governing body that establishes an actuarially sound and adequately funded workers' compensation loss reserve account that dedicates the workers' compensation loss reserve account to and limits expenditures to only the payment of compensation and amounts due the director under ORS chapter 656. The resolution must also include the director's first lien and priority rights to the full amount of the workers' compensation loss reserve account required to pay the present discounted value of all present and future claims under ORS chapter 656; and

(D) A statement giving the amount of the current reserves for present and future liabilities, the amount funded in the workers' compensation loss reserve account, and the procedures, methods, and criteria used in the process of determining the amount funded in their actuarially sound workers' compensation loss fund, including procedures for determining the amount for injuries incurred but not reported.

(i) The statement must include the city's, county's, or qualified self-insured employer group's certification that the loss reserve account is actuarially sound and adequately funded if an actuarial study is not available.

(ii) The director may require a city, county, or qualified self-insured employer group to demonstrate its loss reserve account

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is actuarially sound and adequately funded based on an actuarial study requested under OAR 436-050-0175(3)(d). The actuarial study must include an IBNR estimate and a copy of the study must be provided to the director.

(b) Within 45 days of receipt of all application materials required under this section, the director will review the application and supporting documentation and notify the city, county, or qualified self-insured employer group that the request for exemption is approved or denied.

(A) If denied, the notice will provide the reasons for the denial, any requirements for reconsideration, and the right to administrative review as provided by OAR 436-050-0008.

(B) If approved, the notice will include:

(i) The confirmation of the effective date of exemption;

(ii) Authorization for cancellation of any surety bond or ISLOC held as security under ORS 656.407(2) and OAR 436-050-0180; and

(iii) Procedures for release of any government securities or time deposits held as security under ORS 656.407(2) and OAR 436-050-0180.

(3) Inadequately funded loss reserve accounts.

If the director has probable cause to believe the employer's workers' compensation account is inadequately funded, the director may order a city, county, or qualified self-insured employer group to increase the amount of its workers' compensation loss reserve account and to provide documentation of the increase. The city, county, or qualified self-insured employer group must comply within 30 days of the director's order. Probable cause to believe the workers' compensation loss reserve account is not actuarially sound includes, but is not limited to:

(a) The annual audited financial statement under ORS 297.405 to 297.740 not containing a statement by the auditor that the workers' compensation loss reserve account is adequately funded, or containing a disclaimer regarding the auditor's qualifications or ability to determine adequacy of the loss reserve account; or

(b) For qualified self-insured employer groups required by the director to conduct an actuarial study under OAR 436-050-0175(3)(d) and (2)(a)(D) of this rule, the actuarial study not containing a statement by the actuary that the loss reserve account is actuarially sound, or containing a disclaimer regarding the actuary's qualifications or ability to determine the adequacy of the reserves for current or future liabilities.

(4) Cancellation of self-insurance certification or loss reserve.

A city, county, or qualified self-insured employer group that has been exempted from ORS 656.407(2) and desires to cancel its self-insurance certification or elects to discontinue maintaining an actuarially sound and adequately funded workers' compensation loss reserve account must:

(a) Submit a written request to the director at least 60 days before:

(A) The desired cancellation date of the self-insured certification; or

(B) The effective date of discontinuation of the qualifying workers' compensation loss reserve account;

(b) If the city, county or qualified self-insured employer group desires to cancel its self-insurance certification:

(A) The request under section (a) must comply with OAR 436-050-0200; and

(B) Before the effective date of cancellation the city, county, or qualified self-insured employer group must provide a security deposit, as required by the director, in an amount determined under OAR 436-050-0180 and ORS 656.443; and

(c) If the city, county, or qualified self-insured employer group elects to discontinue maintaining an actuarially sound and adequately funded workers' compensation loss reserve account:

(A) Before the effective date of discontinuation of the qualifying workers' compensation loss reserve account, the city, county, or qualified self-insured employer group must provide a security deposit as required by the director under ORS 656.407(2) and OAR 436-050-0180; and

(B) Failure to provide the required security deposit as required under paragraph (A) will result in revocation of the city's, county's, or qualified self-insured employer group's self-insurance certification as of that date.

Statutory authority: ORS 656.407, and 656.726(4)

Statutes implemented: ORS 656.407

Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0190 Using Self-Insured Employers' Security Deposit/Self-Insured Employer Adjustment Reserve/Self-Insured Employer Group Adjustment Reserve/Director-Ordered Assessments of Private Employer Members of Self-Insured Employer Groups

(1) Default, decertification, or cancellation of self-insurance certification.

In the event a self-insured employer defaults, or is unable to make all payments due under ORS chapter 656:

(a) The director will, on behalf of the self-insured employer, assure continued payments in accordance with ORS 656.407, 656.443, and 656.614 and in such a manner as to ensure minimum delay in the processing of injured workers' claims.

(b) If the self-insured employer provides an ISLOC as all or part of its security deposit, and the director demands payment under that ISLOC as provided in OAR 436-050-0165(3)(a)(G), the director may use the funds provided by the ISLOC to the extent necessary to assure continued payments and in such a manner as to ensure minimum delay in the processing of injured workers' claims.

(c) The director may refer the self-insured employer's claims for processing to an assigned claims agent selected under ORS 656.054, or designate the service company responsible for continuing to process the employer's claims.

(d) If a self-insured employer group consisting of private employer members defaults, cancels its self-insurance certification, or is decertified by the director under ORS

656.434, the director may order private employer members of the group to pay an assessment for the group's continuing claim liabilities, under ORS 656.430(7)(a)(D)(i). Failure of the group's members to pay director-ordered assessments under this rule will subject members to civil penalties under ORS 656.745.

(2) Changes in liability or financial viability.

In the event a self-insured employer reorganizes its business, assumes additional liability, acquires new operations, buys an additional business, merges with another business, files bankruptcy, emerges from bankruptcy, or otherwise changes its operation in any manner that affects its workers' compensation claims liability, or financial viability as determined under OAR 436-050-0150 or OAR 436-050-0260, the employer must notify the director of the modification of business within 30 days of the event. Failure to comply with this rule may result in the assessment of civil penalties, revocation of the employer's certification, or both.

Statutory authority: ORS 656.407, 656.434, and 656.726(4)
Statutes implemented: ORS 656.407, 656.443, and 656.614
Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0195 Requirements for Changes in Self-Insured Employer Entity

(1) Notification of deletion of entity or changes in entity, contact information, or ownership.

If there is any change in the entity, changes in addresses, telephone numbers, and points of contact, or ownership of a self-insured employer, or if the self-insured employer wishes to delete an entity from the employer's certification, the employer must notify the director in writing within 30 days after the change occurs.

(2) Adding entities.

If a self-insured employer wishes to add entities to the employer's certification:

(a) The self-insured employer must submit a completed [Form 1865](#), "Endorsement to Include Legal Entity in Self-Insured Certification," signed by an officer of the employer;

(b) Each entity must enter into an agreement, signed by an officer of the entity, making the entity jointly and severally liable for the payment of any compensation and moneys due to the director by the self-insured employer or any other entity included in the employer's certification; and

(c) The director will determine, based on the information provided, the effect of the change on the deposit required and whether the entities can be combined for experience rating purposes.

Statutory authority: ORS 656.407, 656.430, and 656.726(4)
Statutes implemented: ORS 656.407 and 656.430
Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0200 Self-Insured Certification Cancellation; Revocation

(1) Effective period of self-insurance certification.

A self-insured employer's certification remains in effect until:

(a) Revoked as provided under OAR 436-050-0150 to 436-050-0195, ORS 656.434, and ORS 656.440; or

(b) Canceled by the self-insured employer with the approval of the director.

(2) Cancellation of self-insurance certification.

If a self-insured employer wishes to cancel its certification:

(a) The employer must submit a written request to the director. The request must include:

(A) The arrangements that have been made to process present and future claims for which the employer is responsible;

(B) A statement of all present and future claims liabilities for all liabilities incurred during the period of self-insurance; and

(C) Any reports and moneys due the director under ORS 656.506, 656.612, and 656.614.

(b) The request under subsection (a) must be submitted at least 60 days before the desired date of cancellation. If the request to cancel is submitted fewer than 60 days before the desired date of cancellation, or otherwise does not meet the requirements of this section, the director may set a cancellation date later than the date requested.

(c) If the self-insured employer will continue to have subject workers after the cancellation date, the employer must demonstrate compliance with ORS 656.017, before the desired date of cancellation, by causing one of the following to be filed with the director:

(A) Proof of coverage provided by an insurer under ORS 656.407, filed by the insurer;

(B) Notice of client coverage provided by a worker leasing company under OAR 436-180-0110, filed by the worker leasing company; or

(C) A copy of an assigned risk binder issued by the Plan Administrator of the Oregon Workers' Compensation Insurance Plan under OAR 836-043-0044, filed by the Plan Administrator.

(d) If the self-insured employer fails to provide the director evidence of coverage under subsection (c) before the desired date of cancellation, the self-insurance certification, including reports and moneys due the director under ORS 656.506, 656.612, and 656.614, will remain in effect.

(3) Responsibility for processing claims.

If a workers' compensation insurance policy and a self-insurance certification on file with the director are both in effect for the same employer for the same time period, the self-insured employer is responsible for processing claims that occur during the time period.

(4) Revocation of self-insurance certification.

The director may revoke the certification of a self-insured employer that fails to comply with ORS 656.407, 656.430, or these rules; defaults under ORS 656.443; or commits any violation for which a civil penalty may be assessed under ORS 656.745. Notice of revocation will be given as provided in ORS 656.440, except that the director may revoke the certification of a self-insured employer after giving 30 days written notice as provided in ORS 656.430(9).

(5) Release of security after self-insured certification cancellation; revocation.

If the certification of a self-insured employer has been canceled or revoked, the director may accept a policy of paid-up insurance in lieu of the employer's security deposit.

(a) The director may accept a policy of paid-up insurance under the following conditions:

(A) The policy must be issued by an insurer, as defined in OAR 436-050-0005;

(B) The policy must provide that the insurer agrees to assume, without monetary limit, all responsibilities and liability of the self-insured employer under ORS chapter 656 for the period the self-insured employer's certification was in effect;

(C) The policy must not be subject to cancellation; and

(D) The policy must not contain provisions or endorsements that do not comply with ORS chapter 656 or OAR chapter 436, including provisions that limit when a claim may be reported.

(b) The director may consider the following factors when determining whether to accept a policy of paid-up insurance:

(A) The amount of the insurer's surplus, as reported on column 1, line 37 of the Liabilities, Surplus, and Other Funds page of the insurer's Annual Statement under OAR 836-011-0000, relative to the amount of security the self-insured employer is required to maintain under OAR 436-050-0180; and

(B) The amount of the insurer's total adjusted capital relative to the insurer's authorized control level risk-based capital, as reported on column 1, lines 28 and 29 of the Five-Year Historical Data page of the insurer's Annual Statement under OAR 836-011-0000.

(c) Upon accepting a policy of paid-up insurance, the director will release the self-insured employer's security deposit in writing.

(6) Responsibility of self-insured employer after cancellation or revocation.

Cancellation or revocation of a self-insured employer's certification does not relieve the employer from full and primary responsibility for claims administration and payment of compensation under ORS chapter 656 for the period the employer's certification was in effect, unless the director accepts a policy of paid-up insurance under section (5) of this rule.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.434 and 656.440

Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0205 Notice of Self-Insurer's Personal Elections

When a self-insured employer elects to provide coverage for a nonsubject worker under ORS 656.039, the employer must notify the director in writing of the election and of any cancellation of the election within 30 days of the effective date.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.039

Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0210 Notice of Self-Insurer's Place of Business in State; Records Self-Insured Must Maintain

(1) Oregon claims processing location required.

Except as described in section (4) of this rule and OAR 436-050-0230, every self-insured employer must establish and maintain at least one designated Oregon claims processing location as required by ORS 656.455, subject to the following:

(a) The self-insured employer must conduct all claims processing activities necessary to meet the requirements of ORS chapter 656 and OAR chapter 436 from its designated claims processing locations, including, but not limited to:

(A) Processing claims;

(B) Making available all records required under OAR 436-050-0220; and

(C) Responding to specific claims processing inquiries;

(b) At the director's request, the self-insured employer must:

(A) Make claims processing locations accessible during regular business hours or other reasonable times to accommodate periodic audits and examination of records; or

(B) Provide the director electronic access to the records to be audited or examined.

(c) The self-insured employer may process claims subject to ORS chapter 656 remotely. As used in this subsection, to "process claims remotely" means to process claims outside of a self-insured employer's Oregon claims processing location, including at the place of residence of an employee of the employer, as directed from the Oregon claims processing location.

(A) The self-insured employer may not process claims at places of business outside of Oregon that are maintained or operated by the employer or a service company, except as follows:

(i) The self-insured employer may receive claims reports at locations outside of the state if claims are forwarded to an Oregon claims processing location for processing;

(ii) Payments may be made from outside of Oregon as directed from the Oregon claims processing location; and

(iii) The self-insured employer may, with prior approval of the director, have one location, in or out of state, for maintaining payroll records pertaining to premium assessments and other assessments and contributions.

(B) The director may suspend a self-insured employer's authority to process claims remotely from its designated claims processing locations, subject to the following:

(i) The director may suspend a self-insured employer's authority to process claims remotely when:

(I) The director finds the self-insured employer has repeatedly violated ORS chapter 656 or OAR chapter 436; and

(II) The director has reason to believe that the violations are related to the self-insured employer's practice of processing claims remotely.

(ii) The director will not suspend a self-insured employer's authority to process claims remotely until the employer has

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been given notice and the opportunity to be heard through a show-cause hearing with the director. During the show-cause hearing, the employer will be provided an opportunity to:

(I) Present evidence regarding the proposed order to suspend the self-insured employer's authority to process claims remotely; and

(II) Give reason why the employer should be permitted to continue processing claims remotely.

(iii) If the director suspends a self-insured employer's authority to process claims remotely, the employer may not process claims remotely for a specified period of time, up to two years.

(iv) The self-insured employer may request the director restore its authorization by submitting a plan demonstrating its ability and commitment to comply with ORS chapter 656 and OAR chapter 436.

(v) A proposed and final order of suspension issued under this rule is a preliminary order subject to revision by the director, and may be appealed under OAR 436-050-0008.

(2) Notice of self-insured employer's claims processing location.

The self-insured employer must give the director notice of its designated claims processing locations, subject to the following:

(a) The notice must be provided upon application for certification as a self-insured employer; and

(b) The notice must identify:

(A) The self-insured employer's principal place of business, including its street and mailing addresses, telephone number, and a general email address that is monitored on a regular basis, where the director can direct general inquiries;

(B) Contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues;

(C) If the self-insured employer uses more than one claims processing location, or locations operated by service companies as described in section (4) of this rule:

(i) The name of each service company, if applicable;

(ii) The street and mailing addresses of each claims processing location; and

(iii) The name, title, phone number, and email address of a contact person at each claims processing location; and

(D) Any other information requested by the director; and

(c) The information provided under this section must reasonably lead an inquirer to an Oregon certified claims examiner who can respond to inquiries regarding workers' compensation policies, claim filing, claims processing, and claims processing location information within 48 hours, not including weekends or legal holidays.

(3) Changes in place of business.

The self-insured employer must notify the director of a change in any of the information required under section (2) of this rule, subject to the following:

(a) The notice must be filed at least 30 days before the effective date of the change; and

(b) The self-insured employer may use [Form 5188](#), "Insurer Contact Update," to satisfy the requirements of this section.

(4) Service companies.

In lieu of, or in addition to, establishing its own claims processing locations in this state, the self-insured employer may use Oregon claims processing locations operated by service companies to satisfy the requirements of section (1) of this rule. If an employer elects to use claims processing locations operated by one or more service companies with respect to all or any portion of its business:

(a) Each service company must be incorporated in or authorized to do business in Oregon;

(b) The self-insured employer must provide the director with a copy of the service agreement between the employer and each service company for approval. The director must approve the service agreement before the service company begins processing the employer's Oregon claims, regardless of the agreement's effective date. To be approved, the service agreement must:

(A) Be an agreement for claims processing services between the self-insured employer and a service company, and must not be between any other third parties;

(B) Identify the self-insured employer by name, and specify the employer's legal or assumed business name as registered with the Oregon Secretary of State;

(C) Identify the service company by name;

(D) Describe the claims processing services to be provided;

(E) Identify the effective date of the agreement;

(F) Identify the termination date of the agreement, if any;

(G) Grant the service company a power of attorney to act for the self-insured employer in workers' compensation coverage and claims proceedings under ORS chapter 656, subject to the following:

(i) The power of attorney must be effective the same date of the service agreement;

(ii) The power of attorney must not be revocable before all claims processing services provided under the service agreement have concluded;

(iii) The power of attorney must be applicable to all claims processed under the agreement, and may not have unspecified limitations; and

(iv) The service agreement must use language that clearly grants power of attorney to the service company, such as the words "power of attorney" or "attorney-in-fact"; and

(H) Contain only those provisions for workers' compensation activities that are allowed in Oregon; subject to the following:

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(i) The director may approve an agreement that contains provisions for activities not allowed in Oregon if the agreement or an addendum provides that any services or provisions not allowed under Oregon workers' compensation law will not be applied when processing Oregon claims; and

(ii) The director may require existing agreements that contain provisions for activities not allowed in Oregon to be amended accordingly;

(c) Each service company must notify the division of its business in Oregon, subject to the following:

(A) The notice must include the service company's location, mailing address, telephone number, email address, and any other contact information requested by the director;

(B) The notice must be filed before the self-insured employer begins using a place of business operated by the service company as a claims processing location; and

(C) The service company may use [Form 4929](#), "Service Company's Notification of Business in Oregon," to satisfy the requirements of this subsection; and

(d) The self-insured employer or service company must notify the director of a change in any of the information required under (4)(c) of this rule, subject to the following:

(A) The notice must be filed at least 30 days before the effective date of the change; and

(B) The self-insured employer or service company may use [Form 5215](#), "Service Company Contact Update," to satisfy the requirements of this subsection.

(5) Limit on claims processing locations.

The self-insured employer may not have more than three claims processing locations at any time. For the purposes of this section:

(a) Each of the following is considered to be one claims processing location:

(A) Each physical location where the self-insured employer processes claims or maintains records; and

(B) Each physical location where a service company processes the self-insured employer's claims or maintains records; and

(b) If more than one entity, including the self-insured employer or a service company, processes claims at the same physical location, each entity must be counted as a separate claims processing location.

(6) Change in claims processing locations.

If a self-insured employer intends to change the location where claims are processed or records of claims are stored, the self-insured employer must, at least 10 days before the change is effective:

(a) Provide notice of the change to any worker, the estate of any deceased worker, or any worker's beneficiary with an open or active claim that will be processed at the new location, subject to the following:

(A) The notice must include contact information for the new claims processing location, including the name and title of a

contact person, telephone number, email address, and mailing address; and

(B) The self-insured employer must send a copy of the notice to the worker's attorney, if the worker is represented, and to the worker's attending physician.

(b) Provide notice of the change to the director, subject to the following:

(A) The notice must include:

(i) Contact information for the current claims processing location, including the name of the claims processor, the name and title of a contact person, mailing address, telephone number, and email address;

(ii) Contact information for the new claims processing location, including the name of the claims processor, the name and title of a contact person, street and mailing address, if different, telephone number, and email address;

(iii) The effective date of the transfer; and

(iv) Any other information requested by the director; and

(B) The notice must specify if all or a portion of the self-insured employer's claims will be transferred, and if closed and denied claims will be included. If only a portion of the employer's claims will be transferred, the notice must include a listing of the claims being transferred that identifies, for each claim:

(i) The claimant's name;

(ii) The date of injury; and

(iii) The sending processor's claim number; and

(c) The self-insured employer may use [Form 5042](#), "Claim Move Notice," to satisfy the requirements of this section.

Statutory authority: ORS 656.455, and 656.726(4)

Statutes implemented: ORS 656.455

Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0220 Records Self-Insured Employer Must Maintain; Period to be Retained, Removal and Disposition
(1) Records self-insured employers must maintain.

Each self-insured employer is required to maintain the following records in Oregon, to make the records available at an Oregon claims processing location, and to provide the director access to the records upon request:

(a) Written records necessary to ensure compliance with ORS 656.506, 656.612, 656.614, and 656.622 including:

(A) A record of payroll by National Council on Compensation Insurance classification; and

(B) Complete records of all assessments, employer and employee contributions, and all such money due the director;

(b) Written records relating to its safety and health program as required by ORS 656.430(10) and OAR 437-001;

(c) Written records used and relied upon in processing each claim;

(d) A written record of all payments made as a result of any claim, including documentation of:

(A) The amount of the payment;

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- (B) The date the payment was issued;
- (C) The date payment was mailed or delivered; and
- (D) An explanation of the time period between the date the payment was issued and the date the payment was mailed or delivered, if any;
- (e) A written record of all reimbursements and recoveries received on each claim;
- (f) A written record of the approval or denial of claims for supplemental temporary disability benefits under ORS 656.210(5);
- (g) A summary sheet for each claim showing all payments made, separated into disability, medical, and vocational assistance payments showing all reimbursements made and cumulative totals, subject to the following:
 - (A) The record of disability payments should be limited to statutory benefits and not include any additional employer obligations; and
 - (B) Expenses must not be included in any of the three columns required on the summary sheet. "Expenses" are defined in National Council on Compensation Insurance, Workers' Compensation Statistical Plan, Part IV(available from NCCI, www.ncci.com, 800-622-4123); and
 - (h) Written records, or copies of records, of claims processed by prior service companies.
- (2) Availability of records.**

A self-insured employer must make records available by one or more of the following methods:

 - (a) By making the records electronically accessible from an Oregon claims processing locations in real time;
 - (b) By keeping physical copies of the records at an Oregon claims processing location; or
 - (c) By archiving physical copies of the records at a location other than an Oregon claims processing location, under the following conditions:
 - (A) Records of a denied claim may be archived after all the appellate procedures have been exhausted and the denial is final by operation of law;
 - (B) Records of any claim for a compensable injury, including a denied claim that is later found to be compensable, may be archived after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur; and
 - (C) If administrative or judicial review is requested, the claim records may not be archived or disposed of until the review is concluded and the time for an appeal from such review has expired, or at least one year after final payment of compensation has been made, whichever is the last to occur.
- (3) Destruction of claims records.**

The self-insured employer may destroy claim records when the self-insured employer can verify that all potential for benefits to the injured worker or the worker's beneficiaries is gone.
- (4) Retention of payroll records required under this rule.**

Payroll records retained under (1)(a) of this rule may be archived or destroyed at the end of three full calendar years after the calendar year in which the money was remitted.

Statutory authority: ORS 656.455, and 656.726(4)
Statutes implemented: ORS 656.455
Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0230 Out-of-State Recordkeeping and Claims Processing by Self-Insured Employer; Conditions and Procedure for Permit; Revocation

(1) Permission to keep records and process claims outside of Oregon.

Notwithstanding OAR 436-050-0210 and 436-050-0220, with the prior approval of the director a self-insured employer may process claims and make claims records available at a claims processing location outside Oregon, under the following conditions:

- (a) The self-insured employer must submit a written application to the director;
- (A) The application must contain the reasons for the request and the mailing address, telephone number, email address and any other contact information of the location where the records will be kept and the claims processed; and
- (B) The application must provide contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director, and a company email address that is monitored on a regular basis;
- (b) Upon receipt, the director will review the application and notify the employer if the request has been approved or denied. If the request has been denied, the director will notify the employer of the reasons for the denial; and
- (c) The director will not grant permission to any self-insured employer that has committed acts or engaged in a course of conduct that would be grounds for revocation of permission or that are contrary to any of the provisions of this rule.

(2) Requirements.

A self-insured employer that keeps claims records and processes claims at a claims processing location outside Oregon must:

- (a) Process claims and make payment of compensation in an accurate and timely manner;
- (b) Make reports to the director promptly as required by ORS chapter 656 and OAR chapter 436;
- (c) Pay to the director promptly all assessments and other money as it becomes due;
- (d) Increase or decrease its security deposit promptly when directed to do so by the director under ORS 656.407(2);
- (e) Comply with the rules and orders of the director in processing and paying claims for compensation; and
- (f) Provide written records which have been removed from this state to the director as requested within a reasonable time not to exceed 14 days or as otherwise negotiated.

(3) Revocation of permission.

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After notice given as required by ORS 656.455(2), permission granted under this rule will be revoked by the director if the employer has committed acts or engaged in a course of conduct that are in violation of any provisions of this rule.

Statutory authority: ORS 656.455, and 656.726(4)

Statutes implemented: ORS 656.455

Hist: Amended 12/13/21 as Admin. Order 21-055, eff. 1/1/22

436-050-0260 Qualifications of a Self-Insured Employer Group

The director may certify five or more employers as a self-insured employer group if the employers, as a group, meet all the requirements of this rule.

(1) Organization.

The employer group must be organized as:

(a) A corporation or cooperative under ORS chapter 60, 62, or 65;

(b) An intergovernmental entity under ORS 190.003 to 190.110; or

(c) A public entity self-insurance program under ORS 30.282(3).

(2) Designation of responsible parties.

The employers must designate:

(a) A board of trustees; and

(b) An administrator, subject to section (9) of this rule.

(3) Group net worth requirements.

The employers must demonstrate and maintain:

(a) That the combined total of the individual members net worth is at least \$3 million; and

(b) For private employer groups, that each individual member's net worth is at least \$150,000. Private employer groups must obtain annual financial data from all members regarding their individual fiscal year-end net worth.

(4) Excess insurance.

The employers must obtain excess insurance coverage of the type and amounts approved by the director, including a self-insured retention of at least \$300,000.

(5) Claims processing staff.

The employers must establish proof of an adequate staff qualified to process claims by:

(a) Employing and retaining at each claims processing location, at least one claims examiner that is certified under OAR 436-055-0070 to process claims in this state, and is actually involved in the claims processing function; or

(b) Contracting the services of one or more service companies that employ at each claims processing location in this state, at least one claims examiner that is certified under OAR 436-055-0070 to process claims in this state, and that is actually involved in processing the group's claims.

(6) Changes in group membership.

The employers must develop a method approved by the director to notify the director of:

(a) The commencement or termination of membership by employers in the group, and the effect on the remaining combined net worth of the employers in the group; and

(b) If a member who terminates membership in the group will continue to be a subject employer, and if so, what arrangements have been made to continue coverage.

(7) Safety and health loss prevention program.

The employers must establish a safety and health loss prevention program as required by OAR 437-001, and demonstrate that accident prevention is likely to improve through self-insurance.

(8) Commons claims fund.

If applicable, the employers must create a common claims fund approved by the director under OAR 436-050-0300, or specify that the amount calculated under OAR 436-050-0300(3) or (6) is to be included in the self-insured employer group's security deposit under OAR 436-050-0180.

(9) Designation of administrative entity.

The employers must designate an entity for the group responsible for centralized claims processing, payroll records, safety requirements, recording and submitting assessments and contributions and making such other reports as the director may require.

(a) For groups consisting of private employer members, the designated entity may not be a member of the group or the group's board, or a trustee for the group.

(b) With the approval of the director, a self-insured employer group may use service companies as authorized by ORS 656.455 instead of establishing its own place of business in this state. To obtain approval or to change or add service locations, the employer group must:

(A) File, with the director, a copy of the agreement entered into between the employer group and each company; and

(B) Give the director notice of the location, mailing address, telephone number, email address, and any other contact information for each service company.

(10) Proof of financial ability.

Unless exempt under OAR 436-050-0185, the employers must establish proof of financial ability by:

(a) Providing a security deposit that the director determines is acceptable under OAR 436-050-0165, and in an amount determined under OAR 436-050-0180;

(b) Demonstrating financial viability based on factors including, but not limited to:

(A) The group meeting the combined net worth requirements in (3)(a) of this rule;

(B) For private employers that are members of a self-insured group, meeting the individual net worth requirements in (3)(b) of this rule; and

(c) Demonstrating acceptable financial strength by maintaining a rating equal to "strong" or "moderate" as determined under section (11) and (12) of this rule.

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(11) Financial strength analysis.

The financial reports submitted by the self-insured employer group under OAR 436-050-0175(1) must contain information sufficient to calculate the financial ratios described in this section. The points awarded for each ratio will be used to determine the self-insured employer group's financial strength under section (12) of this rule.

(a) For the purposes of calculating the financial ratios under this section:

(A) The face value of a self-insured employer's irrevocable standby letter of credit (ISLOC) used to satisfy the director's requirement for a security deposit, may not be included in the self-insured employer group's reported assets;

(B) **Current assets** include all assets that may be reasonably expected to be converted into cash, or could become the equivalent of cash, within one year in the normal course of business;

(i) **Cash** must include all readily available and unrestricted funds such as bills, coin, or checking account balances. Cash does not include funds held in special deposit or escrow accounts where some degree of legal constraint against their use exists;

(ii) Current assets include, but are not limited to, cash, accounts receivable, inventory, prepaid expenses, and investments, marketable securities and bonds that mature within one year or may be converted to cash without penalties or fees; and

(iii) Current assets must not include fixed assets, accumulated depreciation, intangible assets, or investments, marketable securities, or bonds with maturity dates of one year or longer;

(C) **Current liabilities** are debts and obligations expected to be due within the next year;

(i) Examples of such liabilities include accounts payable, notes payable, accrued taxes, and wages and salaries owed to workers; and

(ii) Current liabilities do not include debts or claims on assets that will be due a year or more in the future or long-term liabilities intended to provide more permanent funds for the business, including bank loans and long-term bonds;

(D) **Earned contributions** are the net revenues from group members' contributions;

(i) Financial statements and reports may otherwise refer to this component as net premium, member contributions, or operating revenue; and

(ii) At the director's discretion, excess insurance premiums may be deducted from earned contributions when there is a reasonable likelihood of performance by the excess insurance carrier; and

(E) **Adjusted net worth** is the net worth reported in the financial statement of the self-insured employer group less disallowed assets;

(i) Disallowed assets are prepaid expenses, inventory, and accounts receivable over 90 days old; and

(ii) Financial statements and reports may otherwise refer to adjusted net worth as net position, net assets, surplus, owner's equity, or shareholders' equity. The adjusted net worth is the total assets minus the sum of the total liabilities and the disallowed assets.

(b) The **current ratio** is calculated by dividing current assets by current liabilities. A maximum of six points are possible for the current ratio, to be awarded as follows:

Ratio		Points
At least 2	=	6 points
At least 1.75	=	5 points
At least 1.6	=	4 points
At least 1.4	=	3 points
At least 1.25	=	2 points
At least 1	=	1 point
Less than 1	=	0 points

(c) The **cash ratio** is calculated by dividing cash by current liabilities. A maximum of six points are possible for the cash ratio, to be awarded as follows:

Ratio		Points
At least 50%	=	6 points
At least 40%	=	5 points
At least 30%	=	4 points
At least 25%	=	3 points
At least 20%	=	2 points
At least 10%	=	1 point
At least 5%	=	0 points

(d) The **premium-to-surplus ratio** is calculated by dividing earned contributions by the group's adjusted net worth. A maximum of six points are possible for the premium-to-surplus ratio, to be awarded as follows:

Ratio		Points
Less than 1	=	6 points
Less than 1.5	=	5 points
Less than 2	=	4 points
Less than 2.25	=	3 points
Less than 2.5	=	2 points
Less than 2.75	=	1 point
2.75 or more	=	0 points

(12) Rating of financial strength.

The self-insured employer group's financial strength will be rated based on the sum of the points awarded under section (11) of this rule.

(a) A sum of 13 to 18 points is equal to a **strong** rating:

(A) The director will approve initial or continued self-insured group certification if the group meets all the requirements of this rule; and

(B) The group's security deposit amount will be determined based on OAR 436-050-0180(1) or (3);

(b) A sum of 7 to 12 points is equal to a **moderate** rating:

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(A) The director will approve initial or continued self-insured group certification if the group meets all the requirements of this rule; and

(B) The group's security deposit amount will be determined based on OAR 436-050-0180(1) and (2), or (3); and

(c) A sum of 0 to 6 points is equal to a **weak** rating;

(A) The director may not approve the application for initial self-insured employer group certification;

(B) For an existing certified self-insured employer group, the director may:

(i) Provide the group notice of the director's intent to revoke its self-insurance certification under OAR 436-050-0340;

(ii) Increase the security deposit calculated in OAR 436-050-0180 by an amount based on factors including, but not limited to, the considerations identified in OAR 436-050-0180(4);

(iii) Allow the amount of the security deposit to be determined based on a certified actuarial study under OAR 436-050-0180(3); or

(iv) Request that the group submit a financial correction plan that demonstrates the group's ability to improve its rating, in a reasonable time period, without hampering the group's ability to pay compensation and other amounts due under ORS chapter 656; and

(C) The director may request additional information or financial reports to verify the employer's financial strength.

(13) Compliance with rules.

The employer group must comply with the requirements of ORS chapter 656 and OAR chapter 436.

(14) Claims processing location.

The self-insured employer group must maintain at least one place of business in this state where the member's claims will be processed and written records of claims and other records kept as required by OAR 436-050-0210 and 436-050-0220.

(15) Failure to maintain qualifications.

The employer group and its members must maintain the qualifications required under this rule.

(a) If a private employer that is a member of a self-insured employer group fails to maintain individual net worth of at least \$150,000, the group must cancel that member's participation in the group under OAR 436-050-0290.

(b) If a certified self-insured employer group fails to maintain the qualifications required in this rule, the director will revoke the self-insured employer group's certification under OAR 436-050-0340.

Statutory authority: ORS 656.407, 656.430, and 656.726(4)
Statutes implemented: ORS 656.407 and 656.430
Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0270 Applying for Certification as a Self-Insured Employer Group: Private Employers

(1) Employers applying for certification as a self-insured employer group must submit:

(a) A completed [Form 1867](#), "Application to Become a Self-Insured Employer Group: Private Employers;"

(b) Proof in the form of a certificate from the Secretary of State's Corporation Division showing the employer group as a corporation or cooperative;

(c) A copy of the bylaws or corporate minutes that include:

(A) Designation of specific individuals as trustees for the corporation or cooperative;

(B) Naming an administrator to administer the financial affairs of the group who may not be a member of the group or the group's board, or a trustee for the group; and

(C) The criteria used by the trustees and administrator when approving applications for new membership and requests for withdrawal by members of the group;

(d) A copy of the fidelity bond provided to the group by the administrator or a copy of the comprehensive crime policy obtained by the group, in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities;

(e) The current financial statements of each member making application demonstrating that the members meet the requirements of OAR 436-050-0260;

(f) An individual report by employer showing the employer's payroll by class and description and loss information for the last four calendar years;

(g) A completed [Form 1866](#), "Group Self-Insured Indemnity Agreement," or another form authorized by the director, that jointly and severally binds each member for the payment of any compensation and moneys due to the director by the group or any member of the group. Government subdivisions do not need to submit this agreement;

(h) Evidence of a safety and health loss prevention program designed to demonstrate that accident prevention will improve due to self-insurance;

(i) Proof of an adequate staff qualified to process claims under OAR 436-050-0260(5);

(j) If applicable, a service agreement between the group and service company that has been signed by both parties that meets the requirements of OAR 436-050-0210(2). The agreement must:

(A) Be submitted at least 14 days before the desired date of certification, and approved by the director before the service company begins processing claims, regardless of the effective date established in the agreement; and

(B) Contain the location, mailing address, telephone number, and any other contact information of the service company;

(k) The type, retention and limitation levels of excess insurance the employers as a group are planning to obtain in accordance with OAR 436-050-0170;

(l) A procedure for notifying the director of:

(A) The commencement or termination of employers within the group and the effect on the remaining combined net worth of the group; and

(B) Arrangements made by an employer leaving the group to continue insurance coverage.

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(m) A program whereby each employer within the group contributes to a common claims fund in accordance with OAR 436-050-0300, or specification if the amount calculated under OAR 436-050-0300(3) or (6) is to be included in the self-insured employer group's security deposit; and

(n) The type of security deposit the employer group wishes to provide, with appropriate justification.

(2) Audited financial statements.

Notwithstanding (1)(e) of this rule, the director may require an audited financial statement before considering an application by a group for self-insurance.

(3) Review of application.

Within 60 days of receipt of all information required under this rule, the director will review the application and notify the employer group that the request for certification as a self-insured employer group is approved or denied:

(a) If the request is denied, the employers will be notified of the reasons for denial; or

(b) If the request is approved, the notice will include:

(A) The amount of security deposit required;

(B) Approval of the type, retention and limitation levels of the excess insurance as determined under OAR 436-050-0170; and

(C) Approval of the service agreement submitted under (1)(j) of this rule.

(4) Issuance of certification.

If approved, the self-insurance certification will be issued upon receipt of the security deposit and the appropriate excess insurance binder. The effective date of certification will be the first day of the month following the date the certification is issued, or a later date specified by the applicant.

Statutory authority: ORS 656.407, 656.430, and 656.726(4)

Statutes implemented: ORS 656.407 and 656.430

Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0280 Applying for Certification as a Self-Insured Employer Group: Governmental Subdivisions

(1) Required information.

Governmental subdivisions applying for certification as a self-insured employer group must submit:

(a) A completed [Form 1867](#), "Application for Self-Insured Employer Group";

(b) Proof that the governmental subdivisions have formed:

(A) An intergovernmental entity as provided under ORS 190.003 to 190.110; or

(B) A self-insurance program under ORS 30.282(3);

(c) An intergovernmental agreement that includes:

(A) Designation of specific individuals as trustees for the group and naming an administrator to administer the financial affairs of the group; and

(B) The criteria to be used by the trustees and administrator when approving applications for new membership and requests for withdrawal by members of the group;

(d) A copy of the fidelity bond provided to the group by the administrator or a copy of the comprehensive crime policy obtained by the group, in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities;

(e) The current financial statements of each member making application, demonstrating the members meet the combined net worth requirement under OAR 436-050-0260;

(f) An individual report by employer showing the governmental subdivision's payroll by class and description and loss information for the last four calendar years;

(g) A resolution by the governing body of each governmental subdivision binding it to be liable for the payment of any compensation and other amounts due to the director under ORS Chapter 656 incurred by that governmental subdivision during the period of group self-insurance;

(h) Evidence of a safety and health loss prevention program designed to demonstrate that accident prevention will improve due to self-insurance;

(i) Proof of an adequate staff qualified to process claims under OAR 436-050-0260(5);

(j) If applicable, a service agreement between the group and service company that has been signed by both parties that meets the requirements of OAR 436-050-0210(2). The agreement must:

(A) Be submitted at least 14 days before the desired date of certification, and approved by the director before the service company begins processing claims, regardless of the effective date established in the agreement; and

(B) Contain the location, mailing address, telephone number, and any other contact information of the service company;

(k) The type, retention and limitation levels of excess insurance the employers as a group are planning to obtain in accordance with OAR 436-050-0170;

(l) A procedure for notifying the director of:

(A) The commencement or termination of governmental subdivisions within the group and the effect on the remaining combined net worth of the group; and

(B) Arrangements made by a governmental subdivision leaving the group to continue insurance coverage;

(m) If applicable, a program whereby each employer within the group contributes to a common claims fund under OAR 436-050-0300, or specification that the amount calculated under OAR 436-050-0300(3) or (6) is to be included in the self-insured employer group's security deposit; and

(n) The type and amount of security deposit the group wishes to provide, with appropriate justification. In no case will the security deposit amount be less than \$300,000.

(2) Audited or certified financial statements.

Notwithstanding (1)(e) of this rule, the director may require an audited or certified financial statement before considering an application by a group for self-insurance.

(3) Review of application.

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Within 60 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the group that the request for certification as a self-insured employer group is approved or denied.

(a) If the request is denied, the notice will include the reasons for denial; or

(b) If the request is approved, the notice will include:

(A) The amount of the security deposit required; and

(B) Approval of the type, retention and limitation levels of the excess insurance as determined under OAR 436-050-0170; and

(C) Approval of the service agreement submitted under (1)(j) of this rule.

(4) Issuance of certification.

If approved, the self-insurance certification will be issued upon receipt of the security deposit, and the appropriate excess insurance binder. The effective date of certification will be the date the certification is issued, or a later date specified by the applicant.

Statutory authority: ORS 656.407, 656.430, and 656.726(4)
Statutes implemented: ORS 656.407 and 656.430
Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0290 Commencement/Termination/Cancellation of Employers with a Self-Insured Employer Group; Effect on Net Worth; Extension of Coverage; Change in Entity; Change of Address; Recordkeeping

(1) Addition of new members.

Prospective new members of a self-insured employer group must submit an application to the board of trustees, or its administrator. The administrator of a group consisting of private employer members may not be a member of the group. The trustees, or administrator, may approve the application for membership under the bylaws of the self-insured employer group. Once approved, the administrator or board of trustees must submit to the director, within 30 days of the effective date of membership, a completed [Form 1869](#), "Endorsement to Self-Insured Group Application" or a form approved by the director, which must be accompanied by:

(a) A current financial statement of the employer applying;

(b) Evidence of at least \$150,000 individual net worth if the prospective new member is a private employer;

(c) An agreement signed by the administrator of the self-insured employer group and the employer, making the employer jointly and severally liable for the payment of any compensation and moneys due to the director by the group or any member of the group; or, if a governmental subdivision self-insured employer group, a resolution by the governing body of each governmental subdivision binding it to be liable for the payment of any compensation and other amounts due to the director under ORS chapter 656 incurred by that governmental subdivision during the period of group self-insurance;

(d) A statement showing the effect on the new combined net worth of the group; and

(e) The employer's payroll by class and description and loss information for the last four fiscal or calendar years.

(2) Incomplete or incorrect submissions.

Incomplete submissions or incorrectly completed endorsements to add new members received by the director will not be considered filed, and the employer will not be included in the self-insurance of the self-insured employer group. Failure to file a correct and complete endorsement with the required supporting documentation within 30 days of the effective date of membership may result in the assessment of civil penalties.

(3) Termination or cancellation of membership.

An individual employer member may elect to terminate its membership in a self-insured employer group or be subject to cancellation by the group under the bylaws of the group, subject to the following:

(a) Groups consisting of private employer members must cancel the membership of any private employer member that fails to maintain the minimum individual net worth required under OAR 436-050-0260(15). Cancellation must occur within 30 days of the group's receipt of the employer member's most recent fiscal year end financial data demonstrating insufficient net worth.

(b) No later than 10 days before the effective date of the member's cancellation, or immediately following the date of the member's termination, the self-insured employer group must submit the following information to the director:

(A) A statement, without disclaimers or qualifying language as to the accuracy of the information provided:

(i) Showing the effect of the employer member's termination or cancellation on the remaining combined net worth of the group; and

(ii) Certifying that the group continues to meet the combined net worth requirements in OAR 436-050-0260;

(B) Evidence that the employer member requesting termination or being canceled has made alternate arrangements for coverage if the member continues to employ subject workers;

(C) Evidence that the employer member requesting termination or being canceled has been provided a written reminder about its potential future liability as described in (1)(c) of this rule; and

(D) The expected date of cancellation or termination.

(c) If an employer member's membership in a self-insured employer group is canceled, terminated, or ceases due to the cancellation or revocation of the group's certification, the group must, upon the member's request, provide the member with the most recent claim loss data for the member as reported to the director under OAR 436-050-0175(3)(a). The group must provide the claim loss data no later 30 days after receiving the member's request.

(4) Revocation of certification due to change in membership.

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If the director determines the cancellation or termination of an employer member adversely affects the self-insured employer group to the extent that the group no longer qualifies for self-insurance certification, the director may revoke the self-insured employer group's certification under OAR 436-050-0340(1).

(5) Change in entity.

If there is a change in the entity of an employer member, the employer member must reapply for membership within the self-insured employer group under this rule. A change in entity includes, but is not limited to:

- (a) A partner joining or leaving a partnership;
- (b) A sole proprietorship, partnership, or corporation, changing to another of those ownership structures; or
- (c) An employer selling an existing business to another person, except in the case of a corporation.

(6) Change in name or address.

An employer member of a group must, within 10 days after there is a change of address or assumed business name, notify the board of trustees or administrator of the change.

- (a) A change of address includes, but is not limited to:
 - (A) Establishment of a new or additional location; or
 - (B) Termination of an existing location.
- (b) The administrator or board of trustees must, within 10 days, submit to the director an endorsement as notice of the change. The endorsement must state specifically which location is being deleted or which is being added and identify if address is the mailing, operating, or the principal place of business of the location.

(7) Maintenance of coverage records.

The self-insured employer group is responsible for maintaining coverage records relating to each employer member, to include:

- (a) The employer member's application for membership in the self-insured employer group, with original signatures;
- (b) The employer member's liability agreement under OAR 436-050-0270(1)(g), or resolution under OAR 436-050-0280(1)(g), with original signatures;
- (c) Cancellation or termination notices;
- (d) Reinstatement applications and notices; and
- (e) Records on the locations of employers that have been canceled or have terminated their participation in the group.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.434 and 656.440
Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0300 Self-Insured Employer Group, Common Claims Fund

(1) Except for qualified self-insured employer groups approved by the director as exempt from security deposit requirements under OAR 436-050-0185, a self-insured employer group must establish and maintain, under the direction and control of the board of trustees and administrator, a common claims fund for the sole purpose of ensuring the availability of funds to make certain the prompt payment of all

compensation and all other payments that may become due from such self-insured employer group under the workers' compensation law. This requirement does not apply in any year in which the director applies an incurred but not reported (IBNR) factor of greater than zero percent in the determination of the self-insured employer group's security deposit under OAR 436-050-0180.

(2) The common claims fund must be maintained in an account held by an Oregon state chartered or a federally chartered bank. Government subdivisions certified as a self-insured employer group may also maintain the common claims fund in a "Local Government Investment Pool" account held by the Office of the State Treasurer.

(3) Except as provided in section (6) of this rule, the balance of the common claims fund must be maintained in an amount at least equal to 30 percent of the average of the group's paid losses for the previous four years. The full sum of the required common claims fund balance must be maintained at all times.

(4) The director may require the self-insured group to increase the amount maintained in the common claims fund.

(5) By March 1 of each year, a self-insured employer group must provide the director with adequate documentation to validate the balance in the common claims fund or notice that the amount calculated under section (3) or (6) of this rule must be included in the determination of the self-insured employer group's security deposit under OAR 436-050-0180. The director may require a self-insured employer group to provide documentation of the common claims fund balance more frequently.

(6) For governmental subdivisions certified as a self-insured employer group, the balance of the common claims fund must be maintained in an amount at least equal to 60 percent of the average of the group's yearly paid losses for the previous four years.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.430
Hist: Amended 12/13/21 as Admin. Order 21-055, eff. 1/1/22

436-050-0340 Group Self-Insurance Revocation

(1) The director may revoke the certification of a self-insured employer group after giving 10 days written notice if:

- (a) The employer group does not comply with ORS 656.430(7) or (8), OAR 436-050-0170 to 436-050-0190, 436-050-0260, or 436-050-0290;
- (b) There are fewer than five employers within a group;
- (c) The net worth of the group falls below that required by OAR 436-050-0260(3);
- (d) The employer group defaults in payment of compensation or other payments due the director;
- (e) The employer group commits any violation for which a civil penalty could be assessed under ORS 656.745; or
- (f) The employer group or any member of the group submits any false or misleading information.

(2) Notice of revocation will be given as provided in ORS 656.440, except that the director may revoke the certification of

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a self-insured employer group after giving 30 days written notice as provided in ORS 656.430(9).

Statutory authority: ORS 656.726(4);

Statutes implemented: ORS 656.430, 656.434, 656.440

Hist: Amended 11/7/22 as Admin. Order 22-065, eff. 1/1/23

436-050-0500 Assessment of Civil Penalties

The director may assess a civil penalty under ORS 656.745(2) against an employer or insurer that violates ORS chapter 656, OAR 436-050, or an order of the director.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.745(2)

Hist: Adopted 12/13/21 as Admin. Order 21-055, eff. 1/1/22

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CERTIFICATION OF CLAIMS EXAMINERS**

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**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 055
CERTIFICATION OF CLAIMS EXAMINERS**

Effective Jan. 1, 2020

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436-055-0003 Applicability and Purpose

(1) Applicability.

These rules apply to the certification of all workers' compensation claims examiners on or after the effective date of these rules.

(2) Purpose.

The purpose of these rules is to establish standards for the certification of workers' compensation claims examiners under ORS chapter 656.

(3) Director's discretion.

The director may waive any procedural rule as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.780

Hist.: Amended 11/8/16 as WCD Admin. Order 16-052, eff. 1/1/17

436-055-0005 Definitions

Except where the context requires otherwise, the definitions under ORS 656.005 and the following apply to OAR 436-055-0008 to 436-055-0110:

(1) "Claims examiner" means anyone who has primary responsibility for decision making or benefit determination in a claim.

(2) "Director" means the director of the Department of Consumer and Business Services or the director's designee.

(3) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(4) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in this state ; an assigned claims agent selected by the director under ORS 656.054; an employer certified under ORS 656.430 that meets the qualifications of a self-insured employer under ORS 656.407; or a service company that processes claims for an insurer or self-insured employer under the conditions prescribed in ORS 731.475(3) and ORS 656.455(1).

(5) "Party" means a claimant for compensation, the employer of the worker at the time of injury, the insurer of the employer, or the insurer's service company, if any.

(6) "Process claims" means the determination of compensability and management of workers' compensation claims.

Stat. Auth.: ORS 656.726(3)(a)

Hist.: Amended 11/8/16 as WCD Admin. Order 16-052, eff. 1/1/17

436-055-0008 Administrative Review and Contested Cases

(1) Requests for hearings on sanctions and civil penalties.

Any party that disagrees with a proposed order, or proposed assessment of civil penalty issued by the director under these rules, may request a hearing by the Hearings Division under ORS 656.740. To request a hearing, the party must:

(a) Mail or deliver a written request to the Workers' Compensation Division within 60 days of the mailing date of the proposed order or assessment; and

(b) Specify, in the request, the reasons why the party disagrees with the proposed order or assessment.

(2) Requests for administrative review.

Any party that disagrees with an action taken under these rules may request an administrative review of the action by the director. To request administrative review, the party must:

(a) Mail or deliver a written request for review to the Workers' Compensation Division within 90 days of the action; and

(b) Specify, in the request, the reasons why the party disagrees with the action.

(3) Requests for hearing on any other action or order of the director.

Any party that disagrees with an action or order of the director, except as described in section (1) of this rule, may request a hearing by filing a hearing request as provided in OAR 436-001-0019 within 60 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 656.735(5) through (7); ORS 656.745(4); ORS 656.726(4)

Stats. Implemented: ORS 656.740, ORS 656.726

Hist.: Amended 11/8/16 as WCD Admin. Order 16-052, eff. 1/1/17

436-055-0070 Certification of Claims Examiners

(1) Claims examiner test.

To become an Oregon certified claims examiner, an individual must complete a test that demonstrates the individual's competency in claims processing activities, subject to the following:

(a) The test must include questions that demonstrate the individual's:

(A) Familiarity with ORS chapter 656;

(B) Ability to navigate OAR chapter 436;

(C) Ability to perform claims processing activities; and

(D) Understanding of all of the components in OAR 436-055-0085(1); and

(b) The individual may use a copy of ORS chapter 656 and OAR chapter 436 during the testing period.

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(2) Initial certification.

An insurer may certify an individual as an Oregon certified claims examiner upon verification of the individual's satisfactory completion of the test under section (1) of this rule. The certification will remain in effect for three years from the date of the test. As used in this section, "satisfactory completion" means:

- (a) The individual received a score of at least 80 percent on the test; and
- (b) The test was not completed through dishonest or fraudulent means.

(3) Renewal of certification.

An insurer may renew a claims examiner's certification upon verification that the claims examiner has completed 24 hours of training within the past three years. The 24 hours of training must include:

- (a) At least six hours of training on ORS chapter 656, OAR chapter 436, and relevant case law;
- (b) At least one hour of training related to interactions with independent medical examination providers that has been approved under OAR 436-055-0085(1); and
- (c) Additional training that covers any of the following subjects:
 - (A) Medical case management including, but not be limited to, medical terminology, basic human anatomy and the interpretation of medical reports;
 - (B) Communication skills including, but not be limited to, courses in ethics, mediation, negotiation and conflict management; or
 - (C) Claims processing skills relevant to Oregon workers' compensation claims.

(4) Expired certification.

An insurer may renew a claims examiner's certification that expired within the past 12 months if the individual meets the requirements of section (3) of this rule. An insurer may recertify a claims examiner who has not held current certification in the past 12 months under section (2) of this rule.

(5) Acknowledgement of certification issued by another insurer.

If an individual provides an insurer with documentation of current certification issued by another insurer, the insurer receiving the documentation may:

- (a) Issue an acknowledgement of the certification stating that the individual has met the requirements for initial certification or renewal, if the documentation is sufficient to verify that the individual has met the requirements for initial certification or renewal; or
- (b) Require the individual to recertify under section (2) of this rule, if the documentation is not sufficient to verify that the individual has met the certification requirements.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.780(1)
Hist.: Amended 11/8/16 as WCD Admin. Order 16-052, eff. 1/1/17

436-055-0085 Training for Interactions with Independent Medical Examination Providers

(1) Director approval of training curricula.

Any training relating to interactions with independent medical examination (IME) providers must follow a curriculum that has been approved by the director. Curricula must include at least some of the following components:

- (a) Appropriate and ethical communication with IME providers;
- (b) Insurers' rights and responsibilities;
- (c) Injured workers' rights and responsibilities;
- (d) IME providers' standards of conduct requirement;
- (e) IME complaint process and investigations by the Workers' Compensation Division; or
- (f) The requirements of ORS 656.325 and OAR 436-010.

(2) Request for approval.

Any person may develop a training curriculum and request approval from the director under this section.

(a) The request for approval must:

- (A) Be made in writing;
 - (B) Describe how the training content relates to the components in section (1) of this rule; and
 - (C) Specify the total number of training hours to be provided.
- (b) The director will approve or deny the request and notify the person of the decision within 30 days of receipt of the request.

(A) If the request is approved, the curriculum will be valid until the content or number of hours of training change, at which time a new request for approval must be submitted.

(B) If the request is denied, the director will notify the person of the reasons for denial. The person may resubmit the request when the reasons for denial have been addressed.

(3) Registry of approved curricula.

The director will maintain a registry of approved training curricula.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.780(1)
Hist.: Amended 11/8/16 as WCD Admin. Order 16-052, eff. 1/1/17

436-055-0100 Insurer Duties

(1) Insurer's responsibility to employ certified or qualified examiners.

An insurer may only employ Oregon certified claims examiners to process claims. An Oregon certified claims examiner must have primary responsibility for all activities related to the determination of compensability and management of a claim including, but not limited to, calculating benefits and authorizing payments to workers.

(2) Claims examiner trainees and temporary claims examiners.

Notwithstanding section (1), an insurer may employ a claims examiner trainee or a temporary claims examiner who is not

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certified to assist with claims processing activities, subject to the following:

(a) A "claims examiner trainee" is an individual hired by an insurer to assist with claims processing activities who has no previous experience as an Oregon certified claims examiner, or who did not have current Oregon claims examiner certification in the 12 months before the date of hire. An individual may only work as a claims examiner trainee for up to 12 months in any five-year period;

(b) A "temporary claims examiner" is an individual hired by an insurer to assist with claims processing activities who has at least two years of prior experience as an Oregon certified claims examiner. An individual may only work as a temporary claims examiner for up to 90 days in any 12-month period;

(c) The claims examiner trainee or temporary claims examiner must work under the direct supervision of a certified claims examiner; and

(d) The claims examiner trainee or temporary claims examiner may not represent the insurer in communications with the director or the Workers' Compensation Board.

(3) Responsibility for training.

An insurer must ensure that training required under these rules, including training related to interactions with independent medical examination providers, is provided for any claims examiners it employs. No provision of these rules is intended to prevent an insurer from providing training to its employees beyond the requirements of these rules.

(4) Records.

An insurer must keep records sufficient to verify the certification and training of all certified claims examiners, temporary claims examiners, and claims examiner trainees it employs to process claims.

(a) The records must include:

(A) The names of all certified claims examiners, claims examiner trainees and temporary claims examiners, currently employed by the insurer;

(B) The names of the certified claims examiners supervising any claims examiner trainee or temporary claims examiner currently employed by the insurer;

(C) The date of certification and date of expiration of certification for each certified claims examiner;

(D) The dates of employment of any temporary claims examiner who has been employed by the insurer within the past 24 months;

(E) The dates of employment of any claims examiner trainee who has been employed by the insurer within the past five years;

(F) Documentation of any qualified trainings completed by each certified claims examiner during the most recent period of certification, including:

(i) The names of the instructors providing the training;

(ii) The syllabi;

(iii) The dates of training; and

(iv) The number of training hours completed for each component under OAR 436-055-0070(3); and

(G) Documentation provided to the insurer to support any acknowledgment of an initial certification or renewal issued by another insurer.

(b) Upon the director's request, the insurer must make the records available for inspection or review.

(c) The insurer must provide a claims examiner with a complete copy of all records verifying the most recent certification and any subsequent training completed by the claims examiner within 14 days of the termination of the claims examiner's employment, or upon receipt of a written request.

(d) The insurer must retain records used to verify the certification and renewal of any certified claims examiner it employs for six years from the date of the most recent certification or renewal.

(5) Civil penalties.

An insurer that fails to comply with the requirements of this rule, or misrepresents information related to the certification of any of its employees to a worker, employer, or the director may be subject to a civil penalty under OAR 436-055-0110.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.780(1) and (2)

Hist.: Amended 11/8/16 as WCD Admin. Order 16-052, eff. 1/1/17

436-055-0110 Assessment of Civil Penalties

(1) Penalties for failure to comply with statutes, rules, and orders.

The director may assess a civil penalty under ORS 656.745(2) against an insurer that violates ORS chapter 656, OAR 436-055, or an order of the director.

(2) Penalties for failure to comply with ORS 656.780.

The director may assess a civil penalty against an insurer that fails to maintain or produce certification and training records as required by these rules, or that employs anyone other than an Oregon certified claims examiner to process claims.

Stat. Auth.: ORS 656.447(1)(a); ORS 656.745(2)(b); ORS 656.780(3)

Hist.: Amended 12/17/19 as Admin. Order 19-063, eff. 1/1/20

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WORKERS' COMPENSATION DIVISION
CLAIMS ADMINISTRATION**

**Administrative
Order No.
24-053**

**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 060
CLAIMS ADMINISTRATION**

Effective July 1, 2024

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436-060-0003 Purpose, Applicability, Forms, and Bulletins

(1) Purpose.

The purpose of the rules in OAR 436-060 is to prescribe uniform standards for insurers to process workers' compensation claims under ORS chapter 656.

(2) Applicability.

(a) The rules are subject to the applicability provisions under ORS 656.202.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(3) Forms and bulletins.

(a) The forms and bulletins referenced in OAR 436-060 are available on the division's website at <https://wcd.oregon.gov/forms/Pages/index.aspx>.

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(b) With the approval of the director, an insurer may modify the appearance, wording, or font size of a paper form referenced in OAR 436-060. Any insurer modified paper form must:

(A) Obtain information equivalent to the division's current form;

(B) Use the same form number as the division's current form;

(C) Have an appearance and format substantially similar to the division's current form; and

(D) Have an asterisk after the form name with the following statement at the bottom "“This form was modified by [INSERT INSURER'S NAME], and has been approved for use by the Oregon Workers' Compensation Division.”"

(c) The director may revoke approval of an insurer modified paper form when the director determines the form does not comply with current federal or state law, or if the director finds the form no longer meets the requirements of (3)(b) of this rule.

(d) To request approval of a modified paper form, the insurer must send or hand deliver the proposed form, along with a cover letter requesting approval to use the form, to the Forms and Bulletins Coordinator at

WCD.FormsBulletins@dcbs.oregon.gov or 350 Winter Street NE, P.O. Box 14480, Salem OR 97309-0405.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 84.013, 192.318, 192.355, 656.005, 656.126, 656.160, 656.202, 656.204, 656.206, 656.208, 656.210, 656.212, 656.214, 656.216, 656.228, 656.230, 656.234, 656.236, 656.245, 656.260, 656.262, 656.263, 656.264, 656.265, 656.268, 656.273, 656.277, 656.278, 656.289, 656.307, 656.308, 656.313, 656.325, 656.331, 656.360, 656.362, 656.386, 656.605, 656.704, 656.726(4), and 656.745

Hist: Amended 12/9/20 as WCD Admin. Order 20-062, eff. 1/1/21

Statutory minor correction (to DCBS email address) – ORS 183.335(7), (WCD 14-2021) filed and effective 10/27/21

436-060-0005 Definitions

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made a part of these rules. For the purpose of these rules unless the context requires otherwise:

(1) "**Aggravation**" means an actual worsening of the compensable conditions after the last award or arrangement of compensation that satisfies the requirements of ORS 656.273.

(2) "**Authorized nurse practitioner**" means a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010.

(3) "**Board**" means the Workers' Compensation Board and includes its Hearings Division.

(4) "**Business days**" means Monday through Friday, excluding legal holidays. Legal holidays are those listed in ORS 187.010 and 187.020.

(5) "**Date stamp**" means to stamp or display the initial receipt date and the recipient's name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.

(6) "**Dependent**" means any of the individuals listed under ORS 656.005(10) who, at the time of an accident, depended in whole or in part for support on the earnings of a worker who dies as a result of an injury.

(7) "**Designated paying agent**" means the insurer temporarily ordered responsible to pay compensation for a compensable injury under ORS 656.307.

(8) "**Director**" means the director of the Department of Consumer and Business Services or the director's designee.

(9) "**Disposition**" or "**claim disposition**" means the written agreement to release rights or obligations under ORS 656.236.

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

(11) "**Employer**" means a subject employer under ORS 656.023.

(12) "**Inpatient**" means a worker who is admitted to a hospital before and extending past midnight for treatment and lodging.

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

(14) "**Mailing date**," unless otherwise specified, means:

(a) The date a document is postmarked;

(b) The date automatically produced by electronic transmission (e.g., email or facsimile);

(c) The date a hand-delivered document is received by the recipient; or

(d) The date of a phone or in-person request, when allowed under these rules.

(15) "**Physical rehabilitation program**" means any services provided to a worker to prevent the compensable injury from causing continuing disability.

(16) "**Regularly employed**" means a worker is receiving a regular wage as defined in section (19) of this rule. For workers who are paid a daily wage, "regularly employed" means actual employment or availability for such employment.

(17) "**Service company**" means the contracted agent for an insurer authorized to process claims and make payment of compensation on behalf of the insurer.

(18) "**Suspension of compensation**" means a period of time where:

(a) No temporary disability, permanent total disability, or medical and related service benefits accrue or are payable; and

(b) Vocational assistance and payment of permanent partial disability benefits will be stayed.

(19) "**Wages**" is as defined in ORS 656.005(27) and, in these rules, is categorized as either irregular wages or regular wages. Wages do not include expenses incurred due to the job and reimbursed by the employer (e.g., meals, lodging, per diem, equipment rental).

(a) "**Irregular wages**" means a variable pay rate at which the service rendered is recompensed under the contract of hiring in

force at the time of the accident, and it includes but is not limited to:

(A) Tips;

(B) Commissions;

(C) Monies paid on unscheduled or unpredictable intervals, including, but not limited to, workers who are seasonally employed, on call, paid hourly at varying hours, or paid by piece rate; and

(D) The reasonable value of any in-kind considerations only if the considerations will not continue during the period of disability.

(b) **"Regular wages"** means a constant and uniform pay rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, and it includes, but is not limited to, wages paid on a daily or weekly basis. Hourly wages may be considered regular if the same number of hours are worked each pay period.

(20) **"Wage earning agreement"** means the verbal or written contract of hiring or terms of employment made between the worker and employer.

(21) **"Written"** means expressed in writing, including electronic transmission.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.005 and 656.726(4)

Hist: Amended 12/19/22 as WCD Admin. Order 22-067, eff. 1/1/23

Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0008 Administrative Review and Contested Cases

(1) Request for hearing on an action concerning a worker's right to compensation.

Any party, or assigned claims agent, that disagrees with an action taken under these rules that concerns a worker's right to compensation, or the amount of compensation due, may request a hearing by the board under ORS chapter 656 and OAR chapter 438.

(2) Request for hearing on proposed sanctions or civil penalties.

Any party, or assigned claims agent, that disagrees with a proposed order or proposed assessment of civil penalty of the director issued under ORS 656.254, 656.260, 656.735, 656.740, or 656.745 may request a hearing by the board. To request a hearing the party, or assigned claims agent, must:

(a) Mail or deliver a written request for hearing to the division within 60 days of the mailing date of the proposed order or assessment; and

(b) Specify, in the request, the reasons why they disagree with the proposed order or assessment.

(3) Administrative review of a matter other than a matter concerning a claim.

Any party, or assigned claims agent, that disagrees with an action taken under these rules, except as described in section (1) of this rule, may request the director to conduct an administrative review of the action. To request administrative review, they must:

(a) Mail or deliver a written request for review to the division within 90 days of the contested action. Requests mailed or delivered more than 90 days after the contested action may be considered if the director determines there was good cause for delay, or that substantial injustice may otherwise result ; and

(b) Specify, in the request, the reasons why they disagree with the contested action.

(4) Request for hearing on a matter other than a matter concerning a claim.

Any party, or an assigned claims agent, that disagrees with an action or order of the director under these rules, other than as described in sections (1) and (2) of this rule, may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Statutory authority: ORS 656.704, 656.726(4), and 656.745

Statutes implemented: ORS 656.254, 656.260, 656.704, 656.726(4), 656.735, 656.740(1), 656.745, and 656.750

Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

SMC (repeal of ORS 656.750)— ORS 183.335(7), filed and effective 6/18/24

436-060-0010 Employer Responsibilities

(1) General.

A subject employer must accept notice of a claim for workers' compensation benefits from a worker or the worker's attorney under ORS 656.265.

(a) [Form 801](#), "Report of Job Injury or Illness," must be readily available for workers to report their injuries. The employer must provide Form 801 to the worker:

(A) Immediately upon request by the worker or worker's attorney under ORS 656.265(6); or

(B) Upon receiving notice or knowledge of an accident that may involve a compensable injury under ORS 656.262(3)(a).

(b) [Form 827](#), "Worker's and Health Care Provider's Report for Workers' Compensation Claims," signed by the worker, is written notice of an accident that may involve a compensable injury. The signed Form 827 will start the claim process, but does not relieve the worker or employer of the responsibility of filing [Form 801](#).

(c) [Form 3283](#), "A Guide for Workers Recently Hurt on the Job," may be printed on the back of Form 801, and must be provided by the employer to the worker if any of the following circumstances occur:

(A) The worker files a claim for workers' compensation benefits.

(B) The worker is evaluated at an on-site medical service facility to assess the nature or extent of a work injury and the employer has notice or knowledge of the work injury.

(d) If a worker provides notice of a claim using an electronic form, the insurer may require the worker to sign a medical release form, so the insurer can obtain medical records necessary to process the claim under OAR 436-010-0240.

(2) Employer reporting time frame.

An employer, except a self-insured employer, must report a claim to its insurer no later than five days after the date the

employer has notice or knowledge of any claim or accident that may result in a compensable injury. The date an employer has knowledge of an accident that may result in a compensable injury is the earliest date any supervisor or manager of the employer has enough facts to reasonably conclude that workers' compensation liability is a possibility.

(3) Reporting requirements.

The report must provide the information requested on Form 801, and include at least:

- (a) The worker's name and address;
- (b) The employer's legal name and address; and
- (c) The information required under ORS 656.262 and 656.265.

(4) Injuries not requiring medical services.

The employer is not required to notify the insurer of an accident that does not require the worker to seek treatment from a licensed medical service provider, subject to the following:

(a) The employer must report the claim to the insurer under section (2) of this rule, if:

- (A) The worker chooses to file a claim;
- (B) The worker signs a [Form 801](#);
- (C) The worker or employer is billed for treatment; or
- (D) The employer learns that the injury has resulted in medical services, disability or death. For the purposes of this paragraph, the date of that knowledge under section (2) of this rule is the date the employer received notice or knowledge of the medical services, disability, or death; and

(b) If the employer does not give the insurer notice under this section:

- (A) The employer must maintain records for five years showing the name of the worker, the date of the accident, the nature of the injury and treatment provided; and
- (B) These records must be available for inspection by the director, the worker or the worker's attorney, if any, and the insurer.

(5) Civil penalty for failure to report claims.

The director may assess a civil penalty under OAR 436-060-0200 against an employer that:

- (a) Is late in reporting more than ten percent of its total claims to its insurer during any quarter; or
- (b) Intentionally or repeatedly pays compensation instead of reporting claims or accidents that may result in a compensable injury to its insurer.

(6) Worker's right to choose medical service provider.

The worker may choose a medical service provider, attending physician or authorized nurse practitioner under ORS 656.245, 656.260, OAR 436-010 and 436-015. Except as provided under ORS 656.260 and OAR 436-015, if an employer restricts the worker's choice of medical service provider the director may impose a civil penalty of up to \$2,000.

Statutory authority: ORS 656.265(6), 656.726(4), and 656.745
Statutes implemented: ORS 656.245, 656.260, 656.262, 656.265, and 656.745
Hist: Amended 12/9/20 as WCD Admin. Order 20-062, eff. 1/1/21
Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0011 Insurer Reporting Requirements

(1) General.

The insurer must process and file claims and reports required by the director in compliance with ORS chapter 656, OAR chapter 436, and orders of the director.

(a) All forms must be legible and include all information required by this rule.

(b) The insurer may not submit forms, or their electronic equivalents, by email, facsimile, electronic data interchange (EDI), or other electronic means, without the director's prior authorization.

(c) Electronic forms, when allowed, must include the same fields and elements as their paper counterparts.

(2) Misdirected claims.

If an insurer receives a claim and did not provide coverage for the worker's employer on the date of injury, the insurer must forward the claim to either the correct insurer or the director within three days of the date it determined it was not responsible for the claim.

(3) Identification of insurer.

All workers' compensation forms generated by the insurer must include:

- (a) The insurer's name;
- (b) The service company's name, if applicable; and
- (c) The mailing address and phone number of the location responsible for processing the claim.

(4) Claims status and activity reporting.

The insurer must report all disabling claims status and activity to the director using [Form 1502](#), "Insurer's Report."

(a) The insurer must file a Form 1502 with the director within 14 days of:

(A) The date of the insurer's initial decision to accept or deny the claim;

(B) The date of any reopening of the claim, except voluntary reopening under ORS 656.278;

(C) The date of a change in the acceptance or classification of the claim following the initial Form 1502;

(D) The date of a litigation order or insurer's decision that changes the acceptance or classification of the claim, or causes the claim to be reopened;

(E) The date a worker is enrolled in a managed care organization that occurs after the initial [Form 1502](#) has been filed;

(F) The date the insurer has knowledge that a previously filed Form 1502 contained erroneous information;

(G) The date of a denial that occurs after the initial Form 1502 has been filed; or

(H) The date first payment of temporary disability is issued, if the date was not included in the initial Form 1502.

(b) Each Form 1502 the insurer files must include the following information:

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- (A) The worker's legal name;
 - (B) The worker's Social Security number as provided by the worker or employer, or a statement that the insurer is unable to obtain the worker's Social Security number;
 - (C) The insurer's claim number;
 - (D) The date of injury;
 - (E) The employer's legal name;
 - (F) The employer's policy number, unless the employer is self-insured or the claim is a noncomplying employer claim;
 - (G) The status of the claim;
 - (H) The reason for filing; and
 - (I) The wrap-up project name, if the claim is from a wrap-up project.
- (c) The Form 1502 reporting the insurer's initial decision to accept or deny a claim must also include:
- (A) If the first payment of compensation was made within the time frame required under OAR 436-060-0150, if applicable;
 - (B) If the claim was accepted or denied within the time frame required under OAR 436-060-0140; and
 - (C) For a worker enrolled in a managed care organization:
 - (i) The date of enrollment; and
 - (ii) The managed care organization number, unless the number was reported on a prior Form 1502 on the claim.
- (5) Filing the first Form 1502 on a claim.**
- The first Form 1502 the insurer files on a claim must be accompanied by:
- (a) Copies of all acceptance and denial notices not previously submitted to the director; and
 - (b) A signed [Form 801](#), or its electronic equivalent, except when a Form 801 is not available for timely filing.
- (A) The Form 801 must be completed by the employer and worker, unless:
- (i) The Form 801 cannot be obtained from the employer or worker because the employer or worker cannot be located, refuses to cooperate, or is physically unable to complete the form; or
 - (ii) The Form 801 was prepared using an electronic form that required it to be prepared by the insurer based upon information obtained from the employer and worker.
- (B) If a Form 801 is not available for timely filing:
- (i) The [Form 1502](#) may be accompanied by a signed [Form 827](#) to satisfy the initial reporting requirement; and
 - (ii) The Form 801 must be submitted within 30 days of the date the insurer filed the first Form 1502.
- (6) Nondisabling claims.**
- The insurer is not required to report a nondisabling claim to the director, except:
- (a) The insurer must report a nondisabling claim that is denied in part or whole to the director within 14 days of the date of denial; and

(b) The insurer must report a nondisabling claim that is reclassified as disabling to the director within 14 days of the date of the status change.

(7) Voluntarily reopened own motion claims.

The insurer must file a [Form 3501](#), "Notice of Voluntary Reopening Own Motion Claim," with the director within 14 days of the date the insurer voluntarily reopens a qualified claim under ORS 656.278.

(8) New condition reopening.

If the insurer reopens a claim due to a new medical condition, and the claim:

(a) Is not closed within 14 days, the insurer must file [Form 1502](#) with the director within 14 days of the earliest of:

- (A) The date the new condition is accepted; or
- (B) The date the insurer has knowledge that interim temporary disability compensation is due and payable; or

(b) Is closed within 14 days, the insurer must report the reopening on the [Form 1503](#), "Insurer Notice of Closure Summary." Form 1503 must be filed with the director at the time the insurer closes the claim, and accompanied by the "Modified Notice of Acceptance" and "Updated Notice of Acceptance at Closure" sent to the worker.

(9) Claim withdrawal.

The insurer must file a [Form 1502](#) with the director if it receives written communication from the worker stating the worker never intended to file a claim and wants the claim withdrawn after the claim has been reported to the director. The Form 1502 must be accompanied by a copy of the worker's communication.

(10) Failure to report.

The director may issue a civil penalty against any insurer that does not file required notices and forms within the time frames of these rules.

(11) Reporting of legal service costs.

Insurers must make an annual report to the director reporting attorney fees, attorney salaries, and all other costs of legal services paid under ORS chapter 656. The report must be submitted on forms provided by the director for that purpose. Reports for each calendar year must be filed by March 1 of the following year.

(12) Election of payment of supplemental disability.

If an insurer elects to not process and pay supplemental disability benefits under ORS 656.210(5)(a) and OAR 436-060-0035:

(a) The insurer must submit a [Form 3530](#), "Supplemental Disability Election Notification," to the director. The insurer is not required to inform the director if it elects to process and pay supplemental disability unless the insurer has previously provided notice otherwise.

(b) The insurer must use a [Form 3504](#), "Supplemental Disability Benefits Quarterly Reimbursement Request," to request reimbursement under OAR 436-060-0500 for each

quarter the insurer processed and paid supplemental disability benefits.

Statutory authority: ORS 656.264, 656.265(6), 656.726(4), and 656.745
Statutes implemented: ORS 656.210, 656.262, 656.264, and 656.745
Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

436-060-0012 Notices and Correspondence Following the Death of a Worker

(1) If a worker is deceased, regardless of the cause of death, an insurer must:

(a) Address all future notices and correspondence to the estate of the worker or qualified beneficiaries;

(b) Provide a written notice of acceptance or denial of a claim to the estate of the worker; and

(c) Issue a Notice of Closure, when applicable, to the estate of the worker. The insurer must mail the worker's copy of the Notice of Closure to the worker's last known address. The insurer may mail copies of the Notice of Closure to any known or potential beneficiaries.

(2) Other notices required under this chapter intended for the worker are not required when the worker is deceased.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.262, 656.264, and 656.268
Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

436-060-0015 Required Notice and Information

(1) Notice to worker's attorney.

If a worker is represented by an attorney, and the attorney has given written notice of representation, the insurer must provide written notice to the worker's attorney before, or at the same time, as the insurer:

(a) Requests the worker to submit to a medical examination;

(b) Contacts the worker regarding any matter that may result in denial, reduction, or termination of the worker's benefits; or

(c) Contacts the worker regarding any matter relating to the disposition of a claim under ORS 656.236.

(2) Penalty for failure to provide notice to worker's attorney.

The director may assess a civil penalty against an insurer that intentionally or repeatedly fails to give notice as required under section (1) of this rule.

(3) Information provided to worker.

The insurer or service company must provide:

(a) [Form 1138](#), "What happens if I'm hurt on the job?" to every worker who has a disabling claim with the first disability check or earliest written correspondence. For nondisabling claims, [Form 3283](#), "A Guide for Workers Recently Hurt on the Job," may be provided in place of Form 1138, unless the worker specifically requests Form 1138;

(b) [Form 3283](#) to its insured employers. Form 3283 may be printed on the back of [Form 801](#);

(c) [Form 3058](#), "Notice to Worker," or an equivalent form, to the worker with the initial notice of acceptance of the claim under OAR 436-060-0140(6). If an equivalent form is provided, it must include all of the information included on Form 3058;

(d) The additional notices required under OAR 436-060-0018, 436-060-0030, 436-060-0035, 436-060-0095, 436-060-0105, 436-060-0135, 436-060-0140, and 436-060-0180; and

(e) With the first disability check or earliest written correspondence, contact information that will:

(A) Reasonably lead the worker to an Oregon certified claims examiner during regular Oregon business hours; and

(B) Reasonably ensure that inquiries from the worker are responded to within 48 hours, not including Saturday, Sunday, or legal holidays under ORS 187.010 and 187.020.

(4) Notice of change of processing location.

When the insurer changes claims processing locations, service companies, or self-administration, the insurer must provide at least 10 days prior notice to workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, email address, and mailing address of the new claim processor.

(5) Notice of change in rate of compensation and benefit amounts.

When the insurer changes the rate of compensation, the wage used to calculate benefit amounts, or the method of calculation used to determine benefits, the insurer must provide a written explanation of any change to the worker and the worker's attorney, if any.

(6) Notice of wage used to calculate benefits at closure.

Before closure of a disabling claim the insurer must send a notice to the worker that:

(a) Documents the wage upon which benefits were based;

(b) Informs the worker that work disability, if applicable, will be determined when the claim is closed; and

(c) Explains how the worker can appeal the insurer's wage calculation if the worker disagrees with the wage.

(7) Notice of end of temporary disability benefits.

In addition to other requirements in OAR chapter 436, the insurer may not end temporary disability benefits until written notice has been mailed or delivered to the worker and the worker's attorney, if the worker is represented. The notice must state the reason that temporary disability benefits are no longer due and payable. This notice requirement does not apply to temporary disability benefits paid under ORS 656.210(4).

(8) Notice of medically stationary status.

An insurer must mail or deliver a written notice to a worker and the worker's attorney, if the worker is represented, within seven days following receipt of information that the worker is medically stationary.

Statutory authority: ORS 656.331, 656.726(4), and 656.745
Statutes implemented: ORS 656.331, 656.262, 656.268, 656.726(4), and 656.745
Hist: Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24
Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0017 Release of Claim Documents

(1) For the purpose of this rule:

(a) "**Documents**" means the written records making up, or relating to, the worker's claim, including but not limited to:

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(A) Medical records, including any correspondence to and from medical experts who provide reports to the insurer;

(B) Vocational records, including any correspondence to and from vocational experts who provide reports to the insurer;

(C) Records of all compensation paid;

(D) Payroll records;

(E) Recorded statements;

(F) Insurer generated records, excluding a claims examiner's generated file notes, such as documentation or justification concerning setting or adjusting reserves, claims management strategy, or any privileged communications;

(G) All forms and notices on the claim required by ORS chapter 656 or OAR chapter 436;

(H) Notices of closure; and

(I) Electronic transmissions and correspondence between the insurer, service providers, worker, director, or board.

(b) Any documents generated or received by the insurer five or more business days before the mailing date of a request for copies of claims documents are considered to be in the insurer's or service company's possession, even if the documents have not reached the insurer's or service company's claim file.

(2) Date of receipt.

The insurer or service company must date stamp each document in its possession on the date received.

(3) Requests for claims documents.

The insurer or service company must provide, without charge, legible copies of documents in its possession relating to a claim, upon request of the worker, worker's attorney, worker's beneficiary, or beneficiary's attorney at times other than those provided for under ORS 656.268 and OAR chapter 438, as provided in this rule.

(a) A request for copies of claim documents must be submitted to the insurer or service company, and copied simultaneously to the insurer's defense counsel, if known.

(b) Except as provided in OAR 436-060-0180, an initial request by anyone other than the worker or worker's beneficiary must be accompanied by an attorney retainer agreement or a medical release that has been signed by the worker.

(A) The signed medical release must be provided using [Form 2476](#), "Request for Release of Medical Records for Oregon Workers' Compensation Claim," or an equivalent form.

(B) Information not otherwise available through this release, but relevant to the claim, may only be obtained in compliance with applicable state or federal laws.

(c) If the worker or beneficiary is represented by an attorney:

(A) The documents must be mailed directly to the worker's or beneficiary's attorney;

(B) The insurer is not required to provide copies to both the worker or beneficiary and the attorney; however, the insurer must inform the worker or beneficiary that the documents were mailed to the attorney if the documents were requested by the worker or beneficiary; and

(C) If the worker or beneficiary changes attorneys, the insurer must provide the new attorney with copies upon request.

(d) If the worker's or beneficiary's attorney makes an ongoing request for documents:

(A) The insurer must provide all new documents received and generated by the insurer for 180 days after the initial mailing date under section (5) of this rule, or until a hearing is requested before the board; and

(B) The insurer must provide new documents to the worker's or beneficiary's attorney every 30 days. If the attorney requests that specific documents be sent sooner, those documents must be provided within the time frame specified in section (5) of this rule.

(e) The insurer must provide to the worker or the worker's attorney the entire health information record in its possession, except the following may be withheld:

(A) Information obtained from someone other than a health care provider under a promise of confidentiality and access to the information would likely reveal the source of the information;

(B) Psychotherapy notes;

(C) Information compiled for use in a civil, criminal, or administration action or proceeding; or

(D) Information that must be withheld under federal regulation.

(f) If a hearing is requested before the board, the release of documents is controlled by OAR chapter 438 until the hearing request is withdrawn or the hearing record is closed, provided a request for documents is renewed.

(4) Format of documents.

The insurer may provide electronic or paper copies of documents requested under this rule, except that the insurer must provide paper copies if the worker, worker's attorney, worker's beneficiary, or beneficiary's attorney specifically requests paper copies.

(5) Time frame to provide documents.

The insurer must provide copies of documents requested under this rule within the following time frames:

(a) For files that are not archived, documents must be mailed within 14 days of receipt of a request;

(b) For files that are archived, documents must be mailed within 30 days of receipt of a request;

(c) If a claim is lost or has been destroyed, the insurer must notify the requester and the director in writing within 14 days of receiving the request for claim documents. The insurer must reconstruct and mail the file within 30 days from the date of the lost or destroyed file notice; and

(d) If the insurer does not possess any documents at the time the request is received:

(A) The insurer must mail any documents relating to the claim it receives to the requestor within 14 days of receipt of the documents; and

(B) The request will be considered ongoing for 90 days.

(6) Complaints of violation.

Complaints about a violation of the rules regarding release of requested claims documents must be made in writing and mailed or delivered to the division within 180 days of the request for documents, and must include a copy of the request submitted under section (3) of this rule.

(a) When notified by the director that a complaint has been filed, the insurer must mail or deliver a written response to the director within 14 days of the mailing date of the director's inquiry letter. A copy of the response, including any attachments, must be simultaneously mailed to the requester of claim documents.

(b) If the director does not receive a timely response or the insurer provides an inadequate response (e.g., failing to answer specific questions or provide requested documents), the director may assess a civil penalty against the insurer under OAR 436-060-0200. Assessment of a penalty does not relieve the insurer of its obligation to provide a response.

(7) Failure to provide documents.

The director may assess a civil penalty against an insurer that fails to provide documents as required under this rule. The matrix attached to these rules in Appendix "A" will be used in assessing penalties.

Statutory authority: ORS 656.726(4) and 656.745

Statutes implemented: ORS 656.360, 656.362, and 656.745.

Hist: Amended 12/13/21 as WCD Admin. Order 21-056, eff. 1/1/22

Statutory minor correction – ORS 183.335(7), filed and effective 1/3/22

**436-060-0018 Nondisabling and Disabling Claim
Reclassification**

(1) General.

If the insurer changes the classification of an accepted claim, the insurer must:

(a) Notify the director under OAR 436-060-0011;

(b) Send the worker and the worker's attorney, if any, a "Modified Notice of Acceptance" explaining the change in status; and

(c) Close the claim under ORS 656.268(5), if the claim qualifies for closure.

(2) Reclassification of a nondisabling claim.

The insurer must reclassify a nondisabling claim to disabling:

(a) Within 14 days of receiving information that:

(A) Temporary disability is due and payable;

(B) The worker is medically stationary within one year of the date of injury and the worker will be entitled to an award of permanent disability; or

(C) The worker is not medically stationary, but there is a reasonable expectation that the worker will be entitled to an award of permanent disability when the worker does become medically stationary; or

(b) Upon acceptance of a new or omitted condition that meets the disabling criteria in this section.

(3) Worker request for reclassification.

A worker may request the insurer review the classification of a nondisabling claim under ORS 656.277 if the claim has been classified as nondisabling for one year or less after the date of acceptance and the worker believes the claim was or has become disabling.

(a) The request for classification status review must be first made to the insurer in writing.

(b) Within 14 days of receipt of the worker's request, the insurer must review the claim and:

(A) If the classification is changed to disabling, provide notice under this rule; or

(B) If the insurer believes evidence supports denying the worker's request to reclassify the claim, the insurer must mail a "Notice of Refusal to Reclassify" to the worker and the worker's attorney, if any. The notice must include:

(i) The following statement, in bold text:

"If you disagree with this Notice of Refusal to Reclassify, you may appeal by contacting the Workers' Compensation Division within sixty (60) days of the mailing date of this notice. You may appeal by using Form 2943, "Worker Request for Claim Classification Review," available on the division's website at wcd.oregon.gov.

Send written appeals to the Workers' Compensation Division, Appellate Review Unit, PO Box 14480, Salem OR 97309-0405

Or fax to: 503-947-7794

Or hand-deliver to: Workers' Compensation Division, Appellate Review Unit, 350 Winter Street NE, 2nd Floor, Salem OR 97301

You may appeal by phone by calling the Appellate Review Unit at 503-947-7816. A member of the Appellate Review Unit will complete and sign Form 2943 as the worker's designee and they will send a copy of the completed form to you, the insurer, and any attorneys involved in the claim.

If you do not appeal to the Workers' Compensation Division within 60 days of the mailing date of this notice, you will lose all rights to review of this decision. For assistance, you may call the Workers' Compensation Division at 503-947-7816, or the Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)."

(ii) Effective no later than Oct. 1, 2024, the statement in (B)(i) of this subsection must be replaced with the following language in bold and formatted as follows:

If you disagree with this Notice of Refusal to Reclassify, you may appeal by contacting the Workers' Compensation Division. To appeal:

- Contact the division within 60 days of the mailing date of this notice.**

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- You may use Form 2943, "Worker Request for Claim Classification Review," available on the division's website at wcd.oregon.gov.
- Request review in writing or by phone.

Send, hand deliver, or fax written requests to:

Workers' Compensation Division
Appellate Review Unit
350 Winter Street NE, 2nd Floor PO Box 14480
Salem OR 97309-0405 Fax: 503-947-7794

Or, call the Workers' Compensation Division at 503-947-7816. The division will complete and sign Form 2943 on your behalf, and will send copies of the completed form to you, the insurer, and any attorneys involved in the claim.

If you do not appeal to the Workers' Compensation Division within 60 days of the mailing date of this notice, you will lose all rights to appeal this decision.

For help, call:

- Workers' Compensation Division at 503-947-7816
- Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)

(c) If the worker disagrees with the insurer's decision in the Notice of Refusal to Reclassify, the worker may appeal to the director under section (7) of this rule:

(A) The appeal must be made no later than the 60th day after the mailing date of the Notice of Refusal to Reclassify; and

(B) A copy of the insurer's Notice of Refusal to Reclassify must be provided to the director.

(d) If the insurer does not respond to the worker's request for reclassification within 14 days of receipt of the worker's request:

(A) The worker may request review by the director under section (7) of this rule as if the insurer issued a Notice of Refusal to Reclassify;

(B) The director may assess civil penalties under OAR 436-060-0200; and

(C) The director may assess an attorney fee under ORS 656.386(3).

(e) If the worker is represented by an attorney, and the attorney is instrumental in obtaining an order from the director that reclassifies the claim from nondisabling to disabling, the director may order a reasonable assessed attorney fee under ORS 656.277 and OAR 436-001-0435.

(4) Time frame for aggravation rights.

A claim for aggravation under ORS 656.273 must be filed within five years after:

(a) The first valid closure of a claim that is reclassified from nondisabling to disabling within one year from the date of acceptance; or

(b) The date of injury of a claim that is not reclassified from nondisabling to disabling within one year from the date of acceptance.

(5) Claims for aggravation on nondisabling claims.

When a claim has been classified as nondisabling for at least one year after the date of acceptance, a worker who believes the claim was or has become disabling may submit a claim for aggravation under ORS 656.273.

(6) Reclassification of a disabling claim.

If a claim has been accepted and classified as disabling:

(a) All aspects of the claim are classified as disabling and may not be reclassified, unless:

(A) The claim has been classified as disabling for less than one year from date of acceptance;

(B) The insurer determines the criteria for a disabling claim were never satisfied; and

(C) The insurer has notified the worker and the worker's attorney, if any, by issuing a Modified Notice of Acceptance. The Modified Notice of Acceptance must include:

(i) The following statement in bold text:

"Notice to Worker: Your claim has been reclassified to nondisabling. Generally, this means your insurer concluded no disability payments are due and all of the following are true:

You were able to return to work at full wages on or before the fourth calendar day after leaving work or losing wages as a result of your injury.

You did not lose time or wages from work as a result of your injury on or after that fourth calendar day.

It appears you will not have any permanent disability as a result of your injury.

If you think there is a mistake in the classification of your claim as nondisabling, contact the insurer within one year of the date the insurer first accepted your claim and request reclassification.

If you request reclassification, the insurer must complete its review and send you its decision within 14 days of receiving your request. If you disagree with the insurer's decision, you have the right, within 60 days of the date of the insurer's notice, to request that the Workers' Compensation Division review your claim to determine if it was correctly classified. If the insurer does not respond to your request for reclassification within 14 days of receiving your request, you may ask the Workers' Compensation Division to review your claim as though the insurer refused to reclassify your claim. For assistance, you may call the Workers' Compensation Division at 503-947-7816, or the Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)."

(ii) Effective no later than Oct. 1, 2024, the statement in (C)(i) of this subsection must be replaced with the following language in bold and formatted as follows:

Notice to worker:

We have changed your claim to nondisabling. Generally, this means no disability payments are due and all of the following are true:

- You were able to return to work with full wages by the fourth calendar day after leaving work or losing wages because of your injury.
- You did not lose time or wages from work because of your injury on or after that fourth calendar day.
- It appears you will not have any permanent disability because of your injury.

If you disagree that your claim is nondisabling, you may request that we change your claim to disabling.

- You must send us your request in writing within one year of the date we first accepted your claim.
- We must review and send you our decision within 14 days of receiving your request.

If you disagree with our decision, or we do not respond to your request, you have the right to appeal to the Workers' Compensation Division. To appeal:

- You must ask the division to review your claim within 60 days of the date we mailed you our decision.
- If we did not respond within 14 days of receiving your request, ask the division to review your claim as if we refused to change your claim.

For help, call:

- Workers' Compensation Division at 503-947-7816
- Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)

(b) Any subsequently accepted conditions or aggravations must be processed as disabling claims; and

(c) Claim closure must be processed under ORS 656.268.

(7) Appeal of insurer's classification decision.

If a worker disagrees with an insurer's decision to not reclassify the worker's claim from nondisabling to disabling, the worker may appeal the decision by requesting review by the director:

(a) The request must be submitted to the division by mail, hand-delivery, fax, or phone within 60 days from the date of the insurer's notice;

(b) The worker may use [Form 2943](#), "Worker Request for Claim Classification Review," for requesting review of the insurer's claim classification decision; and

(c) The worker does not need to be represented by an attorney to appeal the insurer's reclassification decision under section (3) or (6) of this rule. If a worker appeals an insurer's reclassification decision:

(A) The worker's appeal must be copied to the insurer;

(B) The director will acknowledge receipt of the appeal in writing to the worker, the worker's attorney, if any, and the insurer, and initiate the review;

(C) Within 14 days of the director's acknowledgement:

(i) The insurer must provide the director and all other parties with the complete medical record and all official actions and notices on the claim. The director may impose penalties against an insurer under OAR 436-060-0200 if the insurer fails to provide claim documents in a timely manner; and

(ii) The worker may submit any additional evidence for the director to consider. Copies must be provided to all other parties at the same time; and

(D) After receipt and review of the required documents, the director will issue an order:

(i) The worker and the insurer have 30 days from the mailing date of the order to appeal the director's decision to the board; and

(ii) The director may reconsider, abate, or withdraw any order before the order becomes final by operation of law.

Statutory authority: ORS 656.268, 656.277, 656.386, 656.726(4), and 656.745

Stats. Implemented: ORS 656.210, 656.212, 656.214, 656.262, 656.268, 656.273, 656.277, 656.386, and 656.745

Hist: Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24

Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0019 Determining and Paying the Three-Day Waiting Period

(1) Determining the three-day waiting period.

The three-day waiting period is three consecutive calendar days, beginning with the first day the worker leaves work or loses wages as a result of the compensable injury, subject to the following:

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

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

(c) If the worker leaves work and does not complete the work shift, that day is considered to be the first day of the three-day waiting period, even if there is no loss of wages; and

(d) If the worker leaves work or loses wages during a work shift that extends into another calendar day, the first day of the

three-day waiting period is the date the employer uses for payroll purposes.

(2) Authorization of temporary disability.

Authorization of temporary disability under OAR 436-010-0210 is not required to begin the three-day waiting period.

(3) Paying the three-day waiting period.

No temporary disability compensation is due to the worker for the three-day waiting period, unless temporary disability is authorized under OAR 436-010-0210, and:

(a) The worker is totally disabled after the injury, and the total disability continues for a period of 14 consecutive days; or

(b) The worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability.

(4) Amount due when the three-day waiting period is payable.

When the worker is eligible for compensation for the three-day waiting period under section (3) of this rule, the amount due and payable is determined by applying the following:

(a) If the worker left work during the first half of the shift on the first day of the three-day waiting period, and did not return to complete the shift, the worker must be paid compensation for one half of that day; or

(b) If the worker left work during the second half of the shift on the first day of the three-day waiting period, the worker is not due compensation for that day.

(5) Worker employed with varying days off or a cyclic work schedule.

If a worker is employed with varying days off or a cyclic work schedule, the three-day waiting period must be determined using the work schedule of the week the worker first leaves work or loses wages as a result of the injury.

(6) Worker no longer employed with the employer at injury.

If the worker is no longer employed with the employer at injury, or does not have an established schedule when the worker leaves work or loses wages, the three-day waiting period and scheduled days off must be based on the work schedule of the week the worker was injured.

Statutory authority: ORS 656.210 656.212, and 656.726(4)

Statutes implemented: ORS 656.210 and 656.212

Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

436-060-0020 Payment of Temporary Total Disability Compensation

(1) Employer payment of temporary disability.

An employer may pay temporary disability compensation with the approval of the insurer. If the insurer approves an employer to make such payment:

(a) The insurer continues to be responsible for determining the worker's entitlement to compensation, and ensuring timely payment of compensation;

(b) The employer must provide the insurer with payment documentation that is adequate to meet the insurer's responsibilities; and

(c) The insurer must reimburse the employer for any temporary disability compensation paid to the worker under this section.

(2) Persons who have withdrawn from the workforce.

No temporary disability is due and payable for any period of time in which the person has withdrawn from the workforce. For the purpose of this rule, a person who has withdrawn from the workforce, includes, but is not limited to:

(a) A person who, before a claim reopening under ORS 656.267, 656.273 or 656.278, was not working and made no reasonable efforts to obtain employment, unless such efforts would be futile as a result of the compensable injury.

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

(3) Authorization of temporary disability compensation.

No compensation is due and payable after the worker's attending physician or authorized nurse practitioner ceases to authorize temporary disability, or for any period of time when temporary disability benefits are not authorized by a medical service provider under ORS 656.245(2)(b). Temporary disability compensation is authorized when:

(a) The medical service provider provides the insurer or employer with oral or written verification of the worker's inability to work;

(b) Documents in the insurer's possession at claim closure reasonably reflect the worker's inability to work. For the purposes of this rule "documents" and "possession" have the same meaning as in OAR 436-060-0017(1); or

(c) The director determines, at reconsideration of claim closure, there is sufficient contemporaneous medical documentation to reasonably reflect the worker's inability to work under ORS 656.268.

(4) Lack of verification of inability to work.

No temporary disability is due and payable for any period of time during which the insurer has requested from the worker's attending physician or authorized nurse practitioner verification of the worker's inability to work and the physician or authorized nurse practitioner cannot verify it, unless the worker has been unable to receive treatment for reasons beyond the worker's control.

(a) Before withholding temporary disability under this section, the insurer must ask the worker whether a reason beyond the worker's control prevented the worker from receiving treatment.

(A) If no valid reason is found or the worker does not respond or cannot be located, the insurer must document its file regarding those findings.

(B) The insurer must provide the director a copy of the documentation within 20 days, if requested.

(b) If the attending physician or authorized nurse practitioner is unable to verify the worker's inability to work, the insurer may not end temporary disability benefits until written notice has been mailed or delivered under OAR 436-060-0015(7).

(c) When verification of temporary disability is received from the attending physician or authorized nurse practitioner, the insurer must pay temporary disability within 14 days of receiving the verification of any authorized period of temporary disability, unless otherwise denied.

(5) Suspension of benefits.

An insurer may suspend temporary disability benefits without authorization from the director when all of the following circumstances apply:

(a) The worker missed a regularly scheduled appointment with the attending physician or authorized nurse practitioner;

(b) The insurer sent a letter by certified mail to the worker and a letter to the worker's attorney, at least 10 days in advance of a rescheduled appointment, stating that the appointment has been rescheduled with the worker's attending physician or authorized nurse practitioner, stating the time and date of the appointment, and giving:

(A) The following notice, in prominent or bold text:

"You must attend this appointment. If there is any reason you cannot attend, you must tell us before the date of the appointment. If you do not attend, your temporary disability benefits will be suspended without further notice, as provided by ORS 656.262(4)(e)."

(B) Effective no later than Oct. 1, 2024, the notice in (b)(A) of this section must be replaced with the following notice in bold and formatted as follows:

You must attend this appointment. If there is any reason you cannot attend, you must tell us before the date of the appointment. If you do not attend, your temporary disability benefits will be suspended without further notice under Oregon law.*

If you have any questions you may call:

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

***Oregon Revised Statute 656.262(4)(e)**

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

(d) The insurer sends a letter to the worker, the worker's attorney and the division giving the date of the regularly scheduled appointment that was missed, the date of the rescheduled appointment that was missed, the date of the letter being the day benefits are suspended, and:

(A) The following notice, in prominent or bold text:

"Since you missed a regular appointment with your doctor, we arranged a new appointment. We notified you of the new appointment by certified mail and warned you that your benefits would be suspended if you failed to attend. Since you failed to attend the new appointment, your temporary disability benefits have been suspended. In order to resume your benefits, you must schedule and attend an appointment with your doctor who must verify your continued inability to work."

(B) Effective no later than Oct. 1, 2024, the notice in (d)(A) of this section must be replaced with the following notice in bold and formatted as follows:

We have suspended your temporary disability benefits, because you missed a regular appointment with your doctor.

When we arranged a new appointment for [date], we notified you in a letter that was sent by certified mail.

The letter warned you that we would suspend your benefits if you did not attend, and you did not attend the new appointment.

To resume your benefits:

- You must schedule and attend an appointment with your doctor, and
- Your doctor must verify that you are still unable to work.

(6) Verbal release to work.

If temporary disability benefits end because the insurer or employer negotiates a verbal release of the worker to return to any type of work with the worker's attending physician or authorized nurse practitioner, and the worker has not been informed of the release by the attending physician or authorized nurse practitioner or returned to work, the insurer must:

- (a) Document the facts;
- (b) Communicate the release to the worker by mail within seven days. The communication to the worker of the negotiated return-to-work release may be contained in an offer of modified employment; and
- (c) Advise the worker of their reinstatement rights under ORS chapter 659A.

(7) Temporary disability from two or more claims.

When a worker is due concurrent temporary disability under ORS 656.210 or ORS 656.212 as a result of two or more accepted claims:

(a) The director may order one of the insurers to pay the entire amount of temporary disability due; or make a pro rata distribution between two or more of the insurers;

(b) The insurers may request for the director to make a pro rata distribution of compensation due. The request must be in writing, and the insurer must provide a copy to the worker and the worker's attorney, if any;

(c) The director's pro rata order does not apply to:

(A) Any periods of interim compensation payable under ORS 656.262; or

(B) Any benefits due under ORS 656.214 or 656.245;

(d) Claims subject to the pro rata order must be closed under OAR 436-030 and ORS 656.268, when appropriate;

(e) The pro rata distribution ordered by the director only applies to benefits due as of the date all claims involved are in an accepted status. The order pro-rating compensation will not apply to periods where any claim involved is in a deferred status;

(f) The insurers may not prorate temporary disability without the approval of the director, except when the claims involve the same worker, the same employer, and the same insurer. When the insurer prorates temporary disability under this subsection the worker must receive compensation at the highest temporary disability rate of the claims involved.

(8) Premature closure.

If a closure under ORS 656.268 has been found to be premature and there was an open-ended authorization of temporary disability at the time of closure, the insurer must begin payments under ORS 656.262, including retroactive periods, and pay temporary disability for as long as authorization exists or until there are other lawful bases to terminate temporary disability.

(9) Incorrectly denied claims.

If a denied claim has been determined to be compensable by final order, the insurer must begin temporary disability payments under ORS 656.262, including retroactive periods, if the authorization for temporary disability was open-ended at the time of denial, and there are no other lawful bases to terminate temporary disability.

Statutory authority: ORS 656.210(2), 656.245, 656.262 (OL2022, ch. 73, sections 1 & 2), and 656.726(4)

Statutes implemented: ORS 656.210, 656.212, 656.245, 656.262 (OL2022, ch. 73, sections 1 & 2), and 656.307

Hist: Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24

Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0025 Worker's Weekly Wage Calculation and Rate of Temporary Disability Compensation

(1) Continuation of wages, insured employers.

An employer may not continue to pay wages in place of temporary disability benefits. However, with the worker's consent, the employer may pay the worker amounts in addition to the temporary disability benefits due to the worker, if the employer:

(a) Identifies temporary disability benefits separately from other payments; and

(b) Does not withhold payroll deductions from the temporary disability benefits.

(2) Continuation of wages, self-insured employers.

Notwithstanding section (1) of this rule, a self-insured employer may continue to pay the same wage at the same pay interval that the worker received at the time of injury. Such

payment qualifies as timely payment of temporary disability under ORS 656.210 and 656.212. If the self-insured employer continues to pay wages in place of temporary disability benefits under this section:

(a) Normal deductions including but not limited to, taxes, benefits, and voluntary deductions, must be withheld;

(b) The claim must be classified as disabling;

(c) The self-insured employer must report to the division the rate and duration of temporary disability that would have been paid had wages not continued; and

(d) If the pay interval changes or the amount of wages decreases, the worker must be paid temporary disability as otherwise prescribed by the workers' compensation law.

(3) Rate of compensation, generally.

Except when payments are made under section (2) of this rule, the worker must receive compensation as calculated under ORS 656.210 during the period of temporary total disability, subject to the following:

(a) The benefits of a worker who incurs an injury must be based on the worker's wages at the time of injury and may include regular wages, irregular wages, or both;

(b) The benefits of a worker who incurs an occupational disease must be based on the worker's wages at the time there is medical verification the worker is unable to work because of the disability caused by the occupational disease and may include regular wages, irregular wages, or both. If the worker is not working at the time there is medical verification the worker is unable to work because of the disability caused by the occupational disease, the benefits must be based on the worker's wages at the worker's last regular employment;

(c) The benefits of a worker who was employed in multiple jobs at the time of injury, and who is eligible for supplemental disability under ORS 656.210(2)(b) and OAR 436-060-0035, must be based on the worker's earnings from all eligible subject employment under OAR 436-060-0035;

(d) For a worker with a cyclic schedule, the cycle must be considered to have no scheduled days off; and

(e) When a work shift extends into another calendar day, the date of injury used to determine the wage under this section is the date the employer used for payroll purposes.

(4) Calculation of irregular wages.

If the worker receives irregular wages, the insurer must calculate the worker's irregular wages to determine the worker's average weekly wage based on the weekly average of the worker's irregular wages for the period up to 52 weeks before the date of injury or verification of disability caused by occupational disease, subject to the following:

(a) As used in this section:

(A) "New wage earning agreement" means the worker's wage earning agreement changed for reasons other than only a pay rate change, including but not limited to a change of hours worked or a change of job duties. A job assignment from a temporary service provider or worker leasing company as

defined in OAR 436-180 is not considered to be a new wage earning agreement.

(B) "Pay rate change" means an increase or decrease in a previously established pay rate.

(b) If, on the date of injury or verification of disability caused by occupational disease, the worker had been employed by the employer at injury for four weeks or more, and the most recent new wage earning agreement had been in place for four weeks or more, the insurer must average the worker's irregular wages for the period up to 52 weeks of employment before the date of injury or verification of disability caused by occupational disease, subject to the following:

(A) The insurer must exclude any **gap in earnings** of more than 14 consecutive calendar days that was not anticipated in the wage earning agreement;

(B) If the worker began work under a **new wage earning agreement** in the 52 weeks before the date of injury or verification of disability caused by occupational disease, and there has been **no pay rate change** since the beginning of that work, the insurer must average irregular wages only for the weeks worked under the most recent wage earning agreement; and

(C) When there has been a **pay rate change** during the 52 weeks before the date of injury or verification of disability caused by occupational disease, and paragraph (b)(B) of this section does not apply, the insurer must calculate the worker's average weekly hours worked at each pay rate since a new wage earning agreement went into place, but not to exceed 52 weeks. The average weekly hours worked at each pay rate must then be multiplied by the pay rate(s) at the time of injury or verification of disability caused by occupational disease to determine the worker's average weekly wage for these wages. For the purpose of this rule, the "average weekly hours worked" includes all hours paid at an hourly rate which resulted in payment of irregular wages since the new wage earning agreement went into place, but not to exceed 52 weeks. This may include, but is not limited to, pay for regular hours, overtime, vacation, sick leave, paid time off, or bereavement leave. If there are irregular wages not paid at an hourly rate, the worker's average weekly wage under this paragraph must be added to the average of all of those other irregular wages paid at something other than an hourly rate.

(c) If, on the date of injury or verification of disability caused by occupational disease, the worker was employed by the employer at injury for **less than four weeks**, or the worker's most recent new wage earning agreement had been in place for less than four weeks, the insurer must base the rate of compensation on the intent of the worker's wage earning agreement in place at the time of injury or verification of disability caused by occupational disease, as confirmed by the employer and worker.

(5) Calculation of regular wages.

If the worker receives regular wages, the insurer must calculate the worker's regular wages to determine the worker's average weekly wage:

(a) Daily wages must be multiplied by the number of days per week the worker was regularly employed;

(b) Monthly wages must be divided by 4.35; or

(c) Wages for other pay intervals must be calculated on an equivalent basis.

(6) Workers with no wages.

If the worker is a volunteer, adult in custody, or other covered worker that receives no wages, the insurer must calculate the rate of compensation based on the assumed wage used to determine the employer's premium.

(7) Owners and corporate officers.

If the worker is a sole proprietor, partner, officer of a corporation, or limited liability company member, the insurer must calculate the rate of compensation based on the assumed wage used to determine the employer's premium.

(8) Workers employed through a union hiring hall.

For workers employed through a union hiring hall, the insurer must calculate the rate of compensation on the basis of a five-day work week at 40 hours a week, regardless of the number of days actually worked per week.

(a) The rate of compensation for workers employed through a union hiring hall with dates of injury on or after Jan. 1, 2018, must be calculated under this section.

(b) The rate of compensation for workers employed through a union hiring hall with dates of injury from Jan. 1, 2017, through Dec. 31, 2017, must be calculated under this section, unless such calculation would result in a reduction of benefits.

(9) Wage disputes.

If the worker disputes the wage used to calculate the rate of compensation, the insurer must attempt to resolve the dispute by reviewing its records and mathematical calculations, or by contacting the employer to confirm the correct wage. The insurer must then contact the worker with the results of its review and, if the wage was corrected, the new calculation. If the worker does not agree with the wage calculated by the insurer, the worker may request a hearing under OAR 436-060-0008.

Statutory authority: ORS 656.210(2), 656.704, and 656.726(4)

Statutes implemented: ORS 656.210 and 656.704

Hist: Amended 12/19/22 as WCD Admin. Order 22-067, eff. 1/1/23

Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0030 Payment of Temporary Partial Disability Compensation

(1) Rate of temporary partial disability.

The amount of temporary partial disability compensation due a worker must be determined by multiplying the worker's rate of compensation for temporary total disability by the percentage of wages lost by the worker post injury.

(a) To calculate the rate of temporary disability, the insurer must:

(A) Subtract the worker's post-injury wages from any kind of work from the worker's wages at the time of injury under OAR 436-060-0025;

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(B) Divide the difference under paragraph (A) by the worker's wages at the time of injury under OAR 436-060-0025 to arrive at the percentage of loss of wages; and

(C) Multiply the worker's current rate of compensation for temporary total disability by the percentage of loss of wages in paragraph (B).

(b) As used in this rule "post-injury wages" means the sum of:

(A) The wages the worker could have earned by accepting a job offer, or actual wages earned, whichever is greater;

(B) Any unemployment benefits received; and

(C) Any wages received for paid leave, except wages paid in addition to temporary disability compensation with the worker's consent under OAR 436-060-0025(1);

(c) If a worker is not eligible for supplemental disability under OAR 436-060-0035, wages from a secondary employer must only be included in post-injury wages to the extent that the wages from the secondary employer post-injury exceed the wages from the secondary employer at the time of injury.

(d) If the worker's rate of temporary total disability compensation is based on an assumed wage, the rate of temporary partial disability must be calculated by multiplying the rate of temporary total disability by the percentage of hours lost by the worker post injury.

(2) If the worker returns to employment.

The insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation from the date an injured worker returns to regular or modified employment, prior to claim closure.

(a) If the worker is with a new employer, and the insurer asks the worker to provide wage information, the worker is responsible for providing documented evidence of the amount of any wages being earned; and

(b) If the worker fails to provide documentation, the insurer may assume that post-injury wages are the same as or higher than the worker's wages at time of injury.

(3) If the worker fails to begin employment.

Except when the worker refuses modified work under ORS 656.268(4)(c), the insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation as if the worker had begun the employment from the date a worker fails to begin regular or modified employment, and the following conditions have been met:

(a) The employer or insurer:

(A) Notified the attending physician or authorized nurse practitioner of the physical tasks to be performed by the injured worker;

(B) Notified the attending physician or authorized nurse practitioner of the location of the modified work offer; and

(C) Asked the attending physician or authorized nurse practitioner if the worker can, as a result of the compensable injury, physically commute to and perform the job.

(b) The attending physician or authorized nurse practitioner agreed the employment appears to be within the worker's capabilities, and considering the compensable injury the worker is physically able to commute the lesser of the distance from:

(A) The worker's residence at the time of injury to the work site; or

(B) The worker's residence at the time of the modified work offer to the work site; and

(c) The employer or insurer confirmed the offer of employment in writing to the worker stating:

(A) The beginning time, date, and place;

(B) The duration of the job, if known;

(C) The wages;

(D) An accurate description of the physical requirements of the job;

(E) The attending physician or authorized nurse practitioner has found the job to be within the worker's capabilities and the commute to be within the worker's physical capacity;

(F) The worker's right to refuse the offer of employment without termination of temporary total disability if any of the following conditions apply:

(i) The offer is at a site more than 50 miles from the location where the worker was injured or where the worker customarily reported for work, unless the work site is less than 50 miles from the worker's residence, or the job at the time of injury involved multiple or mobile work sites as established by the intent of the employer and worker at the time of hire or the employment pattern before the injury;

(ii) The offer is not with the employer at injury;

(iii) The offer is not at a work site of the employer at injury;

(iv) The offer is not consistent with existing written shift change policy or common practice of the employer at injury or aggravation; or

(v) The offer is not consistent with an existing shift change provision of an applicable union contract; and

(G) The following notice:

(i) In prominent or bold text:

"If you refuse this offer of work for any of the reasons listed in this notice, you should write to the insurer or employer and tell them your reasons for refusing the job. If the insurer reduces or stops your temporary total disability and you disagree with that action, you have the right to request a hearing. To request a hearing you must send a letter objecting to the insurer's actions to the Worker's Compensation Board, 2601 25th Street SE, Suite 150, Salem, Oregon 97302-1282."

(ii) Effective no later than Oct. 1, 2024, the text in (G)(i) of this subsection must be replaced with the following language in bold and formatted as follows:

If you refuse this offer of work for any of the reasons listed in this notice, you should:

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- Write to the insurer or employer, and
- Tell them your reasons for refusing the job.

If the insurer reduces or stops your temporary total disability, you may appeal by requesting a hearing. To request a hearing, send a letter objecting to the insurer's actions to:

**Worker's Compensation Board
2601 25th Street SE, Suite 150
Salem OR 97302-1280**

(4) If the worker has been terminated from employment.

The insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation as if the worker had begun the employment from the date the worker's attending physician or authorized nurse practitioner approves employment in a modified job that would have been offered to the worker if the worker had not been terminated from employment for violation of work rules or other disciplinary reasons, under the following conditions:

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

(b) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (1) of this rule;

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

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

(5) If the worker is in violation of federal immigration law.

The insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation as if the worker had begun the employment when the attending physician or authorized nurse practitioner approves employment in a modified job whether or not such a job is available if the worker is a person present in the United States in violation of federal immigration laws, under the following conditions:

(a) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (1) of this rule;

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

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

(6) If the modified job no longer exists or offer is withdrawn.

Temporary partial disability must be paid at the full temporary total disability rate as of the date a modified job no longer exists or the job offer is withdrawn by the employer.

(a) This section applies to situations including, but not limited to, termination of temporary employment, layoff, or plant closure.

(b) A worker who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim is subject to this section.

(c) For the purpose of this rule, when a worker who has been doing modified work quits the job, or the employer terminates the worker for violation of work rules or other disciplinary reasons, it is not a withdrawal of a job offer by the employer, but must be considered the same as the worker refusing wage earning employment under ORS 656.325(5)(a).

(d) This section does not apply to those situations described in sections (3), (4), and (5) of this rule.

(7) Termination of temporary partial disability.

When the worker's disability is partial only and temporary in character, temporary partial disability compensation under ORS 656.212 must continue until:

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

(b) The compensation is terminated by order of the director or by claim closure under ORS 656.268; or

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

(8) Verbal release to work.

If temporary disability benefits end because the insurer or employer negotiates a verbal release of the worker to return to any type of work with the worker's attending physician or authorized nurse practitioner, and the worker has not been informed of the release by the attending physician or authorized nurse practitioner or returned to work, the insurer must:

(a) Document the facts;

(b) Communicate the release to the worker by mail within seven days. The communication to the worker of the negotiated return-to-work release may be contained in an offer of modified employment; and

(c) Advise the worker of their reinstatement rights under ORS chapter 659A.

(9) Changes in the rate of compensation.

When the insurer stops paying temporary total disability compensation and starts paying temporary partial disability compensation, or changes the compensation rate or the method of computation of benefits under this rule, the insurer must send

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written notice to the worker and worker's attorney, if any, under OAR 436-060-0015.

Statutory authority: ORS 656.212, 656.704, and 656.726(4)
Statutes implemented: ORS 656.212, 656.268, 656.325(5), 656.704, and 656.726(4)
Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0035 Supplemental Disability for Workers with Multiple Jobs at the Time of Injury

(1) For the purpose of this rule:

(a) **"Primary job"** means the job at which the injury occurred, or the job where the worker was employed at the time of medical verification that the worker is unable to work because of disability caused by occupational disease;

(b) **"Secondary job"** means any other job held by the worker in Oregon subject employment at the time of injury;

(c) **"Temporary disability"** means wage loss replacement for the primary job;

(d) **"Supplemental disability"** means wage loss replacement for the secondary jobs that exceeds the temporary disability, up to, but not exceeding, the maximum established by ORS 656.210; and

(e) **"Insurer"** has the same meaning as OAR 436-060-0005(13), and also includes service companies.

(2) Election to process and pay supplemental disability.

An insurer may elect to be responsible for payment and processing of supplemental disability benefits to a worker employed in more than one job at the time of injury. The insurer is not required to inform the director of its election if it elects to process and pay supplemental disability, unless the insurer's last notice to the director was that it would not process and pay supplemental disability. If the insurer informs the director of its election, the insurer must report its election to the director under OAR 436-060-0011(12).

(a) The election must be made by the insurer, and applies to all service companies an insurer may use for processing claims.

(b) The election remains in effect for all supplemental disability claims the insurer receives until the insurer changes its election.

(c) If the insurer has elected to process and pay supplemental disability benefits:

(A) The insurer must determine the worker's ongoing entitlement to supplemental disability;

(B) The insurer must pay the worker supplemental disability benefits simultaneously with any temporary disability benefits due;

(C) The insurer must maintain a record of supplemental disability benefits paid to the worker, separate from temporary disability benefits paid as a result of the job at injury; and

(D) The director will reimburse the insurer for supplemental disability paid under OAR 436-060-0500.

(d) If the insurer has elected not to process and pay supplemental disability benefits:

(A) The director will select an assigned processing administrator who is authorized to process and pay supplemental disability benefits on behalf of the director;

(B) The assigned processing administrator must determine the worker's ongoing entitlement to supplemental disability and must pay the worker supplemental disability benefits due once each 14 days; and

(C) The insurer and assigned processing administrator must cooperate and communicate, as necessary, to coordinate benefits due.

(i) The assigned processing administrator must provide the insurer with any verifiable documentation of wages from a secondary job received from the worker; and

(ii) The insurer and assigned processing administrator must retain documentation of shared information.

(3) Eligibility for supplemental disability.

A worker who was employed at one or more secondary jobs with Oregon subject employers at the time of injury or medical verification of an occupational disease may be eligible to receive supplemental disability if:

(a) The worker provides notification of the secondary job to the insurer within 30 days of the insurer's receipt of the initial claim;

(b) The rate of compensation for wages at the primary job under OAR 436-060-0025 is less than the maximum temporary disability rate established under ORS 656.210; and

(c) The worker provides verifiable documentation of the wages from any secondary jobs at the time of injury or medical verification of an occupational disease within 60 days of the mailing date of the request for documentation sent under section (4) of this rule. For each secondary job, the documentation must:

(A) Identify the Oregon subject employer for each secondary job;

(B) Establish that the worker held the secondary job, in addition to the primary job, at the time of injury or medical verification of occupational disease; and

(C) Provide adequate information to calculate the average weekly wage under OAR 436-060-0025.

(4) Determination of eligibility.

Upon receiving notification of a worker's secondary job the insurer must determine the rate of temporary disability compensation for wages at the primary job under OAR 436-060-0025, and:

(a) If the rate of temporary disability compensation meets or exceeds the maximum temporary disability rate, the worker is not eligible for supplemental disability benefits; or

(b) If the rate of temporary disability is less than the maximum temporary disability rate, the worker may be eligible for supplemental disability benefits. If the worker may be eligible for supplemental disability benefits, the insurer must:

(A) Mail the worker a request for verifiable documentation of the worker's wages from any secondary jobs within five

business days of notice or knowledge that the worker may be eligible for supplemental disability benefits;

(i) The request must inform the worker what verifiable documentation the worker must submit to the insurer or assigned processing administrator, to determine the worker's eligibility for supplemental disability;

(ii) The request must clearly state that if the insurer or assigned processing administrator does not receive the required documentation within 60 days of the mailing date of the request, the insurer will determine the worker's temporary disability rate based only on the job at which the injury occurred, and the worker will be found ineligible for supplemental disability;

(B) If the insurer has elected not to process and pay supplemental disability benefits under section (2) of this rule, the insurer must also send a copy of the request to the assigned processing administrator. In addition to the requirements of this section, the request must also:

(i) Contain the name, address, email address, and telephone number of the assigned processing administrator;

(ii) Clearly advise the worker that the verifiable documentation must be sent to the assigned processing administrator; and

(C) The insurer or assigned processing administrator must determine the worker's eligibility for supplemental disability within 14 days of:

(i) Receipt of the worker's verifiable documentation; or

(ii) The end of the 60-day period in the insurer's request, if the worker does not provide verifiable documentation.

(c) Any delay in the payment of a higher disability rate because of the worker's failure to provide verifiable documentation under this section will not result in a penalty under ORS 656.262(11).

(5) Notification of eligibility determination.

The insurer or the assigned processing administrator must determine the worker's eligibility for supplemental disability and must communicate the determination to the worker and the worker's attorney, if any, in writing. If the worker is found ineligible for supplemental disability, the letter must also advise the worker of the reason why they are not eligible, and how to appeal if the worker disagrees with the determination.

(6) Calculation of supplemental disability.

The insurer or the assigned processing administrator must calculate supplemental disability for an eligible worker by adding the weekly averages of the worker's wages from each secondary job as calculated under OAR 436-060-0025. For the purposes of calculating and payment of supplemental disability:

(a) The total rate of supplemental disability may not exceed the difference between the maximum rate of temporary disability under ORS 656.210(1) and the rate of compensation for wages under the worker's primary job;

(b) No supplemental disability is due for jobs where the rate of compensation is based on an assumed wage;

(c) In no case may an eligible worker receive less compensation than would be paid if based solely on wages from the primary employer;

(d) The worker's scheduled days off for the primary job must be used to calculate and pay supplemental disability; and

(e) No three-day waiting period applies to supplemental disability benefits.

(7) Partial disability.

When a worker who is eligible to receive supplemental disability benefits has post-injury wages from either the primary job or any secondary job:

(a) The insurer or the assigned processing administrator must calculate the rate of temporary partial disability due to the worker under OAR 436-060-0030 based on the worker's wages from both the primary and secondary jobs;

(b) The insurer or the assigned processing administrator must calculate the amount of supplemental disability by subtracting the rate of partial disability due based on wages from only the primary job from the total rate of compensation due to the worker;

(c) If the worker receives post-injury wages from the secondary job equal to or greater than the secondary wages at the time of injury, no supplemental disability is due; and

(d) If the worker returns to a job not held at the time of the injury, the insurer or the assigned processing administrator must process supplemental disability under the same terms, conditions and limitations as OAR 436-060-0030.

(8) If temporary disability is not due from the primary job.

Supplemental disability may be due on a nondisabling claim even if temporary disability is not due from the primary job.

(a) A nondisabling claim will not change to disabling status due to payment of supplemental disability.

(b) When supplemental disability payments cease on a nondisabling claim, the insurer or the assigned processing administrator must send the worker written notice advising the worker that their supplemental disability payments have stopped and of the worker's right to appeal that action to the Workers' Compensation Board within 60 days of the notice, if the worker disagrees.

(9) Worker's responsibilities.

A worker who is eligible for supplemental disability under this rule has an ongoing responsibility to provide information and documentation to the insurer or the assigned processing administrator, even if temporary disability is not due from the primary job.

(10) Hearings.

If a worker disagrees with the insurer's or the assigned processing administrator's decision about the worker's eligibility for supplemental disability or the rate of supplemental disability, the worker may request a hearing under OAR 436-060-0008.

(a) If the worker requests a hearing on the insurer's decision concerning the worker's eligibility for supplemental disability,

the worker must submit an appeal of the insurer's or the assigned processing administrator's decision within 60 days of the notice in section (5) of this rule.

(b) The insurer for the primary job is not required to contact the secondary job employer. The worker is responsible to provide any necessary documentation.

(11) Sanctions.

An insurer that elects not to process and pay supplemental disability benefits may be sanctioned upon a worker's complaint if the insurer delays sending necessary information to the assigned processing administrator and that delay causes a delay in the worker receiving supplemental disability benefits.

(12) Third party recovery.

In the event of a third party recovery:

(a) Previously reimbursed supplemental disability benefits are a portion of the paying agency's lien; and

(b) Remittance on recovered benefits must be made to the department in the quarter following the recovery in amounts determined in accordance with ORS 656.591 and ORS 656.593.

Statutory authority: ORS 656.210 and 656.726(4)

Statutes implemented: ORS 656.210, 656.212, 656.325(5), 656.704, and 656.726(4)

Hist: Amended 12/13/21 as WCD Admin. Order 21-056, eff. 1/1/22

436-060-0040 Payment of Permanent Partial Disability Compensation

(1) General.

A permanent partial disability award exceeding \$6,000 may be paid monthly by the insurer. If it is paid monthly, it must be paid at 4.35 times the weekly temporary disability rate at the time of closure. A permanent partial disability award less than \$6,000 must be paid under OAR 436-060-0060.

(2) Reopened claims.

If a claim is reopened as a result of a new medical condition, or an aggravation of the conditions resulting from the worker's compensable injury:

(a) Any permanent partial disability benefits due must continue; and

(b) If any temporary disability benefits are due, permanent partial disability benefits must be paid concurrently.

(3) Vocational training plans.

If the worker begins an authorized training plan under OAR 436-120 after claim closure, the insurer must suspend the payment of any work disability award, but continue to pay any impairment award. The insurer must stop temporary disability compensation payments and resume any award payments suspended under ORS 656.268(10) upon the worker's completion or ending of the training, unless the worker is not then medically stationary.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.216, 656.268(10), 656.704, and 656.726(4)

Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

436-060-0045 Payment of Compensation during Worker Incarceration

(1) General.

A worker is not eligible to receive temporary disability compensation for periods of time during which the worker is incarcerated for commission of a crime. All other compensation must be provided the worker as if the worker were not incarcerated, except as provided in OAR 436-120. For the purpose of this rule:

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

(A) In pretrial detention; or

(B) Imprisoned following conviction for a crime; and

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

(2) Initiation of payments after incarceration.

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

(3) Right to claim closure.

A worker who is incarcerated has the same right to claim closure under ORS 656.268 as a worker who is not incarcerated. Any permanent disability awarded must be paid the same as if the worker were not incarcerated.

Statutory authority: ORS 656.160, 656.704, and 656.726(4)

Statutes implemented: ORS 656.160, 656.704, and 656.726(4)

Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

436-060-0055 Payment of Medical Services on Nondisabling Claims; Employer/Insurer Responsibility

(1) General.

Notwithstanding the choice made by the employer under this rule, the employer and insurer must process nondisabling claims in accordance with all statutes and rules governing claims processing. The employer, however, may reimburse the medical service costs paid by the insurer as prescribed in section (3) of this rule.

(2) Notice to employers.

Before the beginning of each policy year, the insurer must notify the insured or prospective insured employer of the employer's right to reimburse medical service costs on accepted, nondisabling claims up to the maximum amount as published in [Bulletin 345](#). The notice must advise the employer:

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

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

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

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

(e) That the employer may participate later in the policy period upon written request to the insurer, however, the earliest reimbursement period is the first completed period, established

under subsection (3)(a) of this rule, following receipt of the employer's request.

(3) Procedure for reimbursement.

If the employer wishes to reimburse the medical service costs paid by the insurer, and has advised the insurer of their election to participate in the reimbursement program in writing under section (2) of this rule:

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

(b) The employer, no later than 30 days after receipt of the list, must identify those claims and the dollar amount the employer wishes to pay for that period and reimburse the insurer accordingly. The employer and insurer may, by written agreement, establish a period in excess of 30 days for the employer to reimburse the insurer;

(c) Failure by the employer to reimburse the insurer within the 30 days allowed by subsection (b) will be deemed notice to the insurer that the employer does not wish to make a reimbursement for that period; and

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

(4) Records.

The insurer must maintain records of amounts reimbursed by employers for medical services on nondisabling claims. For medical service costs reimbursed under this rule:

(a) The insurer may not modify an employer's experience rating or otherwise make charges against the employer based on the costs; and

(b) If the employer is on a retrospective rated plan, the medical costs paid by the employer on nondisabling claims must be included in the retrospective premium calculation, but the insurer must apply the amount paid by the employer as credits against the resulting retrospective premium.

(5) Reclassified claims.

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

(6) Penalties.

Insurers that do not comply with the requirements of this rule or in any way prohibit an employer from reimbursing the

insurer under section (3) of this rule, may be subject to a penalty as provided by OAR 436-060-0200.

(7) Self-insured employers.

Self-insured employers must maintain records of all amounts paid for medical services on nondisabling claims under OAR 436-050-0220. When reporting loss data for experience rating, the self-insured may exclude costs for medical services paid on nondisabling claims in amounts not to exceed the maximum amount published in [Bulletin 345](#).

Statutory authority: ORS 656.262(5), 656.704, 656.726(4), and 656.745
Statutes implemented: ORS 656.262(5), 656.704, 656.726(4), and 656.745
Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

436-060-0060 Lump Sum Payment of Permanent Partial Disability Awards

(1) General.

When an award for permanent partial disability is \$6,000 or less, the insurer must pay the total amount of the award to the worker in a lump sum. When the award for permanent partial disability exceeds \$6,000, the worker or worker's attorney may request a lump sum payment of all or part of the award. The insurer may only deny the request for lump sum payment if any of the following apply:

(a) The worker has not waived the right to appeal the adequacy of the award;

(b) The award has not become final by operation of law;

(c) The payment of compensation has been stayed pending a request for hearing or review under ORS 656.313; or

(d) The worker is enrolled and actively engaged in an authorized training plan under OAR 436-120. For dates of injury before Jan. 1, 2005, the insurer may not approve a request for lump sum payment of unscheduled permanent disability. For dates of injury on or after Jan. 1, 2005, the insurer may not approve a request for lump sum payment of work disability when the worker:

(A) Has been found eligible for an authorized training plan under OAR 436-120 and will start the plan within 30 days of the date of the decision on the lump sum request;

(B) Is actively enrolled and engaged in an authorized training plan under OAR 436-120; or

(C) Has temporarily withdrawn from an authorized training plan under OAR 436-120.

(2) Application for approval.

When an insurer receives a request for a lump sum payment from the worker or the worker's attorney, the insurer must send [Form 1174](#), "Application for Approval of Lump-sum Payment of Award," to the requestor within 10 business days.

(3) Reopening of claims.

For the purpose of this rule, each opening of the claim is considered a separate claim and any subsequent permanent partial disability award from a claim reopening is a new and separate award. Additional award of permanent partial disability obtained through the appeal process is considered part of the total cumulative award for the open period of that claim.

(4) Approved requests.

If the insurer approves the worker's request for lump sum payment of a permanent partial disability award in excess of \$6,000, the insurer must make the lump sum payment within 14 days of receipt of the signed application.

(5) Denied requests.

If the insurer denies the worker's request for lump sum payment of a permanent partial disability award in excess of \$6,000, the insurer must respond to the requestor within 14 days of receiving the request, explaining the reason for denying the lump sum request.

(6) Claim disposition agreements.

A lump sum payment ordered in a litigation order or that is a part of a claim disposition agreement under ORS 656.236 does not require further approval by the insurer.

(7) Partial payments.

When a lump sum payment for only part of an award is approved by the insurer, it must be paid in addition to the regularly scheduled monthly payment. The remaining balance must be paid under ORS 656.216. Denial or partial approval of a request does not preclude another request by the worker for a lump sum payment of all or part of any remainder of the award, provided additional information is submitted.

Statutory authority: ORS 656.704 and 656.726(4)

Statutes implemented: ORS 656.230, 656.704, and 656.726(4)

Hist: Amended 12/19/22 as WCD Admin. Order 22-067, eff. 1/1/23

Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0075 Payment of Death Benefits

If death results from a worker's compensable injury or occupational disease, benefits must be paid as follows:

(1) Final disposition of the body and funeral expenses.

(a) The insurer must pay the cost of final disposition of the body and funeral expenses, up to the maximum benefit under ORS 656.204(1); and

(b) The worker's estate, beneficiaries, or other parties may submit bills related to final disposition of the body and funeral up to 60 days after the date of death or date of claim acceptance, whichever is later. Any portion of the benefit that remains unpaid after this period must be paid to the worker's estate.

(2) Payments to surviving beneficiaries.

The following applies to benefits paid under sections (3) through (5) of this rule:

(a) Benefits payable for a partial month must be calculated by dividing the monthly benefit by the actual number of days in the month and multiplying that result by the number of days payable;

(b) Unless otherwise specified, monthly benefits to beneficiaries must be paid up to the date of any status change; and

(c) Payments must be paid within the timeframes established in OAR 436-060-0150(6).

(3) Benefit to surviving spouse.

If a worker is survived by a spouse, the insurer must pay monthly benefits in an amount equal to 4.35 times 66-2/3 percent of the state average weekly wage to the surviving spouse. Benefits under this section must be paid through the end of the month in which the spouse is no longer eligible to receive benefits under ORS 656.204(2).

(4) Benefit to surviving child.

If a worker is survived by a child under 19 years of age, the insurer must pay a monthly benefit to each child equal to 4.35 times 25 percent of the state average weekly wage, subject to the following:

(a) Total monthly benefits paid under this section must not exceed 4.35 times 133-1/3 percent of the state average weekly wage. If the sum of the individual benefits exceeds this maximum, the insurer must reduce the benefit for each child proportionally;

(b) The insurer may make payment of benefits due under this section to the child's parent, legal guardian, or person having custody of the child. If the child becomes sui juris, the insurer must begin making payment of benefits directly to the child immediately upon the child's written request; and

(c) The insurer must send each child [Form 5332](#), "Notice to Beneficiary of Entitlement to Benefits" at least 90 days before their 18th birthday, informing the child of their right to receive benefit payments directly under subsection (b), and of their entitlement to higher education benefits.

(5) Benefit to surviving dependent.

If a worker is survived by a dependent, the insurer must pay a monthly benefit to each dependent that is equal to 50 percent of the average monthly support the dependent actually received from the worker during the 12 months preceding the occurrence of the accidental injury, subject to the following:

(a) Payments to the dependent must continue until:

(A) The dependent becomes 19 years of age, if the dependent is under the age of 19 years at the time of the accidental injury; or

(B) The time the dependency would have terminated had the injury not happened, if the dependent is 19 years of age or older at the time of the accidental injury;

(b) Within five business days after the date of receipt of a request for benefits from an eligible dependent, the insurer must mail the dependent a request for verifiable documentation of the support the dependent actually received from the worker during the 12 months preceding the occurrence of the accidental injury. The request must:

(A) Inform the dependent what verifiable documentation the dependent must submit to the insurer to calculate the dependent's benefit; and

(B) Clearly state that if the insurer does not receive the required documentation within 60 days of the mailing date of the request, the insurer will determine the dependent's monthly benefit based only on the information in the insurer's possession;

(c) Upon receipt of verifiable documentation or the expiration of the 60-day period in paragraph (5)(b)(B) of this rule, the insurer must:

(A) Determine the dependent's monthly benefit and begin payment under OAR 436-060-0150(6); or

(B) Notify the dependent that the information in the insurer's possession was not sufficient to determine the dependent's monthly benefit and provide information about how the dependent may appeal this decision; and

(d) As used in this section, "verifiable documentation" means any written record of financial support provided to the dependent by the worker including, but not limited to, receipts, billing statements, bank account statements, or signed affidavits.

(6) Benefit to child or dependent attending higher education.

The insurer must pay up to 48 months of benefits during any period in which an eligible child or dependent is between the ages of 19 and 26 and is completing secondary education, is obtaining a general educational development certificate, or is attending a program of higher education, including vocational or technical training.

(a) Benefits under this section must be paid for an entire month. The child or dependent may claim a full month's benefit for any month in which the child is completing secondary education, obtaining a general educational development certificate, or attending a program of higher education for at least one day.

(b) The child or dependent must provide the insurer with documentation that enables the insurer to determine the child's or dependent's eligibility for monthly benefits.

(A) As used in this section, "documentation" includes, but is not limited to, verification of enrollment in a secondary school, general education development certificate program, or program of higher education.

(B) The child or dependent may use [Form 5332](#), "Notice to beneficiary of entitlement to benefits," to satisfy the requirements of this section.

(7) Death during permanent total disability.

If a worker dies during a period of permanent total disability:

(a) The insurer must pay the costs of final disposition of the body and funeral expenses in the same manner and same amounts as provided in section (1) of this rule, subject to the following:

(A) For claims with a date of injury before July 1, 1973, burial benefits are due only if death results from the accidental injury causing the permanent total disability; and

(B) For claims with a date of injury on or after July 1, 1973:

(i) Burial benefits are due if death results from the accidental injury causing the permanent total disability; or

(ii) Burial benefits are due regardless of the reason for death, if the worker was survived by an eligible beneficiary;

(b) The insurer must pay benefits to surviving beneficiaries in the same manner and same amounts as provided in sections (2) through (6) of this rule:

(A) Permanent total disability benefits must be paid through the date of death. Benefits under this section begin to accrue the following calendar day; and

(B) Benefits payable for a partial month must be calculated by dividing the monthly benefit by the actual number of days in the month and multiplying that result by the number of days payable;

(c) The insurer is not required to reopen and close the claim to begin making payments under this section; and

(d) The insurer may not recover an overpayment of permanent total disability benefits from benefits payable to a beneficiary other than the beneficiary that received the overpayment.

Statutory authority: 656.726(4)

Statutes implemented: ORS 656.204, 656.208, and 656.268(14)

Hist: Amended 6/13/22 as Admin. Order 22-057, eff. 7/1/22

436-060-0095 Medical Examinations; Suspension of Compensation; and Independent Medical Examination Notice

(1) General.

A worker must submit to independent medical examinations reasonably requested by the insurer or the director.

(a) The conditions of the examination must be consistent with conditions described in OAR 436-010-0265.

(b) If the worker refuses or fails to submit to, or otherwise obstructs, an independent medical examination reasonably requested by the insurer or the director under ORS 656.325(1), the director may suspend compensation by order:

(A) The worker must have the opportunity to dispute the suspension of compensation before the director will issue the order; and

(B) Compensation will be suspended until the examination has been completed. The worker is not entitled to compensation during or for the period of suspension.

(c) Any action of a worker's observer allowed under OAR 436-010-0265(6) that obstructs the examination may be considered an obstruction of the examination by the worker for the purpose of this rule.

(d) The director may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination.

(e) The director may impose a monetary penalty against the worker under OAR 436-010-0265.

(2) Number of examinations.

The insurer may request no more than three separate independent medical examinations for each opening of a claim, except as provided under OAR 436-010. Examinations after the worker's claim is closed are subject to limitations in ORS 656.268(8).

(3) Scheduling and notice to worker.

**OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
CLAIMS ADMINISTRATION**

Administrative
Order No.
24-053

The insurer may contract with a third party to schedule independent medical examinations. When an examination is scheduled by the insurer, or by a third party at the request of the insurer:

(a) The worker and the worker's attorney, if any, must be simultaneously notified in writing of the scheduled medical examination;

(b) The notice must be mailed at least 10 days before the examination;

(c) If the third party notifies the worker of a scheduled examination on behalf of the insurer, the appointment notice must be sent on the insurer's stationery;

(d) The insurer must include with each appointment notice it sends to the worker:

(A) Form 3921, "Request for Reimbursement of Expenses," or a similar form for requesting reimbursement; and

(B) Form 3923, "Important Information about Independent Medical Exams"; and

(e) The notice sent for each appointment, including those which have been rescheduled, must contain the following:

(A) The name of the examiner or facility;

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

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

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

(E) If applicable, confirmation that the director has approved the examination;

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

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

(H) A statement that the worker has the right to have an observer present at the examination, but the observer may not be compensated in any way for attending the exam; however, for a psychological examination, the notice must explain that an observer is allowed to be present only if the examination provider approves the presence of an observer; and

(I) The following notice:

(i) In prominent or bold text:

"You must attend this examination. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the examination. If you fail to attend and do not have a good reason for not attending, or you fail to cooperate with the examination, your workers' compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.325 and OAR 436-060. You may be charged a \$100 penalty if you fail to attend without a good reason or if you fail to notify the insurer before the examination. The penalty is taken out of future benefits.

If you object to the location of this appointment you must contact the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 or the Ombuds Office for Oregon Workers at 1-800-927-1271."

(ii) Effective no later than Oct. 1, 2024, the text in (I)(i) of this subsection must be replaced with the following language in bold and formatted as follows:

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**

(4) Reimbursement of costs.

When a worker attends an independent medical examination the insurer must reimburse the worker for reasonable costs in accordance with OAR 436-009-0025 regardless of claim acceptance, deferral, or denial.

(5) Forwarding of reports from provider.

Following completion of the examination, the insurer must forward a copy of the examiner's signed report to the attending physician or authorized nurse practitioner within three business days of the insurer's receipt of the report.

(6) Requests to authorize suspension.

The director will consider requests to authorize suspension of benefits on accepted claims, deferred claims, and denied claims in which the worker has appealed the insurer's denial. The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service in the same manner as a summons. The request must include the following information:

- (a) That the insurer requests suspension of compensation under ORS 656.325 and OAR 436-060-0095;
- (b) The claim status and any accepted or newly claimed conditions;
- (c) What specific actions of the worker prompted the request;
- (d) The dates of any prior independent medical examinations the worker has attended in the current open period of the claim and the names of the examining physicians or facilities, or a statement that there have been no prior examinations, whichever is appropriate;
- (e) A copy of any approvals given by the director for more than three independent medical examinations, or a statement that no approval was necessary, whichever is appropriate;
- (f) Any reasons given by the worker for failing to comply, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;
- (g) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the exam received by the insurer from the worker or the worker's attorney will be sufficient documentation with which to request suspension;
- (h) A copy of the notice required in section (3) and a copy of any written verification received under subsection (6)(g) of this rule;
- (i) Any other information that supports the request; and
- (j) The following notice:

(A) In prominent or bold text:

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter

must be mailed within 10 days of the date this request was mailed or personally served on you. If the division grants this request, you may lose all or part of your benefits. If your claim has not yet been accepted, your future benefits, if any, will be jeopardized."

(B) Effective no later than Oct. 1, 2024, the text in (j)(A) of this section must be replaced with the following language in bold and formatted as follows:

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.

(7) Effective date of suspension.

If the director authorizes the suspension of compensation, the suspension will be effective from the date the worker fails to attend an examination or such other date the director deems appropriate until the date the worker undergoes an examination scheduled by the insurer or director. Any delay in requesting consent for suspension may result in authorization being denied or the date of authorization being modified.

(8) Reinstatement of benefits.

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

(9) Claim closure.

If the worker makes no effort to reinstate compensation in an accepted claim within 60 days of the mailing date of the consent to suspend order, the insurer must close the claim under OAR 436-030-0034.

(10) Denial of suspension.

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If the director denies the insurer's request for suspension of compensation, the insurer will be notified of the reason for denial. Failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.

(11) Other actions by the director.

The director may also take the following actions concerning the suspension of compensation:

(a) Modify or set aside the order of consent before or after a request for hearing is filed;

(b) Order payment of compensation previously suspended when the director finds the suspension to have been made in error; and

(c) Reevaluate the necessity of continuing a suspension.

(12) Final orders.

An order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the board.

Statutory authority: ORS 656.325, 656.704, and 656.726(4)

Statutes implemented: ORS 656.325, 656.704, and 656.726(4)

Hist: Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24

Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0105 Suspension of Compensation for Insanitary or Injurious Practices, Refusal of Treatment or Failure to Participate in Rehabilitation; Reduction of Benefits

(1) General.

The director may suspend compensation by order when the worker commits insanitary or injurious acts that imperil or delay recovery; refuses to submit to medical or surgical treatment reasonably required to promote recovery; or fails or refuses to participate in a physical rehabilitation program.

(a) The worker must have the opportunity to dispute the suspension of compensation before the director will issue an order.

(b) The worker is not entitled to compensation during or for the period of suspension.

(2) Notice to worker.

The insurer must demand in writing the worker either immediately cease all actions which imperil or delay recovery or immediately begin to change the inappropriate behavior, and participate in activities needed to help the worker recover from the injury. Each time the insurer sends such a notice to the worker, the written demand must contain the following information, and a copy must be sent simultaneously to the worker's attorney and attending physician:

(a) A description of the unacceptable actions;

(b) Why such conduct is inappropriate, including the fact that the conduct is harmful or delays the worker's recovery, as appropriate;

(c) The date by which the inappropriate actions must stop, or the date by which compliance is expected, including what the worker must specifically do to comply; and,

(d) The following notice of the consequences should the worker fail to correct the problem:

(A) In prominent or bold text:

"If you continue to do insanitary or injurious acts beyond the date in this letter, or fail to consent to the medical or surgical treatment which is needed to help you recover from your injury, or fail to participate in physical rehabilitation needed to help you recover as much as possible from your injury, then we will request the suspension of your workers' compensation benefits. In addition, you may also have any permanent disability award reduced in accordance with ORS 656.325 and OAR 436-060."

(B) Effective no later than Oct. 1, 2024, the text in (d)(A) of this section must be replaced with the following language in bold and formatted as follows:

If you continue this inappropriate conduct after the above date:

- We will ask that your workers' compensation benefits be suspended, and**
- Your permanent disability award, if any, may be reduced under ORS 656.325 and OAR 436-060.**

(3) Failure or refusal to accept medical treatment.

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

(4) Request for suspension of benefits.

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

(a) The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney, if any, by registered or certified mail or by personal service as for a summons.

(b) The request must include the following information:

(A) That the request for suspension is made in accordance with ORS 656.325 and OAR 436-060-0105;

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

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

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(D) How, when, and with whom the worker's failure to comply or refusal to comply was verified;

(E) A copy of the notice required in section (2) of this rule;

(F) Any other relevant information including, but not limited to; chart notes, surgical or physical therapy recommendations/prescriptions, and all recommendations from the attending physician or authorized nurse practitioner; and

(G) The following notice:

(i) In prominent or bold text:

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. If the division authorizes suspension of your compensation and you do not correct your unacceptable actions or show us a good reason why they should be considered acceptable, we will close your claim."

(ii) Effective no later than Oct. 1, 2024, the text in (G)(i) of this subsection must be replaced with the following language in bold and formatted as follows:

Notice to worker:

If the Workers' Compensation Division decides to suspend your benefits and you do not correct your unacceptable actions, or show us a good reason why they are acceptable, we will close your claim.

If you think this request to suspend your benefits 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.

(c) Any delay in obtaining confirmation or in requesting the suspension of compensation may result in authorization being denied or the date of authorization being modified by the date of actual confirmation or the date the request is received by the division.

(d) If the director approves authorization of suspension of compensation:

(A) An order will be issued suspending compensation from a date established under subsection (2)(c) of this rule until the worker complies with the insurer's request for cooperation. Where the worker is suspended for a pattern of noncooperation, the director may require the worker to demonstrate cooperation before reinstating compensation;

(B) The insurer must make all reasonable efforts to assist the worker to reinstate benefits when the worker demonstrates the willingness to make such efforts;

(C) The insurer must monitor the claim to determine if and when the worker complies with the insurer's requests;

(i) When cooperation resumes, payment of compensation must resume effective the date cooperation was resumed;

(ii) If the worker makes no effort to reinstate benefits within 60 days of the mailing date of the suspension order, the insurer must close the claim under OAR 436-030-0034;

(D) The director may modify or set aside the suspension order before or after filing of a request for hearing;

(E) The director may order payment of compensation previously suspended where the director finds the suspension to have been made in error;

(F) The director may re-evaluate the necessity of continuing a suspension; and

(G) The order will become final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the board.

(e) If the director denies the insurer's request for suspension of compensation, the insurer will be notified of the reason for denial. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.

(5) Requests to reduce benefits.

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

(a) When an insurer submits a request to reduce benefits under this section, the insurer must:

(A) Specify the basis for the request;

(B) Include all supporting documentation;

(C) Send a copy of the request, including the supporting documentation, to the worker and the worker's attorney, if any, by certified mail; and

(D) Include the following notice:

(i) In prominent or bold text:

"Notice to worker: If you think this request to reduce your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter

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must be mailed within 10 days of the mailing date of this request. If the division grants this request, you may lose all or part of your benefits."

(ii) Effective no later than Oct. 1, 2024, the text in (D)(i) of this subsection must be replaced with the following language in bold and formatted as follows:

Notice to worker:

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

If you think this request to reduce your benefits 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.

(b) The director will make a decision on a request to reduce benefits and notify the parties of the decision. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the request to reduce benefits.

Statutory authority: ORS 656.325, 656.704, and 656.726(4)

Statutes implemented: ORS 656.325, 656.704, and 656.726(4)

Hist: Amended 12/19/22 as WCD Admin. Order 22-067, eff. 1/1/23

Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0135 Injured Worker, Worker's Attorney Responsible to Assist in Investigation; Suspension of Compensation and Notice to Worker

(1) Worker's responsibility to assist in investigation.

A worker must submit to and fully cooperate with in person or telephone interviews and other formal or informal information gathering techniques reasonably requested by the insurer. Interviews may be recorded on audio or video by one or more of the parties if prior written notice is given of the intent to record an interview.

(2) Request to suspend compensation.

The insurer may request for the director to suspend compensation by order when the worker refuses or fails to cooperate in an investigation of an initial claim for compensation, a claim for a new medical condition, a claim for an omitted medical condition, or an aggravation claim as required by ORS 656.262(14), under the following conditions:

(a) The insurer must notify the worker in writing that an interview or deposition has been scheduled, or of other investigation requirements:

(A) The notice must be sent to the worker and copied to the worker's attorney, if any, and must contain the following:

(i) The date, time, and place of the interview or deposition, if scheduled;

(ii) Any other reasonable investigation requirements;

(iii) That the interview, deposition, or any other investigation requirements are related to the worker's compensation claim; and

(iv) The following statement:

(I) In prominent or bold text:

"The workers' compensation law requires injured workers to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers are required to submit to and fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. If you do not reasonably cooperate with the investigation of this claim, payment of your compensation benefits may be suspended and your claim may be denied in accordance with ORS 656.262 and OAR 436-060."

(II) Effective no later than Oct. 1, 2024, the text in (iv)(I) of this paragraph must be replaced with the following language in bold and formatted as follows:

The law requires you to cooperate and assist in the investigation of your workers' compensation claim. This means you must take part and fully cooperate with:

- Personal and telephone interviews, and

- Other formal or informal information gathering techniques.

If you do not reasonably cooperate:

- Your workers' compensation benefits may be suspended, and

- Your claim may be denied under ORS 656.262 and OAR 436-060.

(B) If the insurer contracts with a third party to investigate the claim, the notice must be on the insurer's stationery and must meet the requirements of this section; and

(C) The worker must be given 14 days to cooperate with the notice.

(b) The director will consider requests to authorize suspension of benefits only after the worker has been given at least 14 days to cooperate with the notice under subsection (a) of this rule; and under the following conditions:

(A) The director will only consider requests in claims on which no acceptance or denial has been issued;

(B) The worker must have the opportunity to submit information disputing the insurer's request for suspension of compensation before the director will issue an order;

(C) The director may determine whether special circumstances exist that would not warrant suspension of compensation for failure to cooperate with an investigation;

(D) The insurer must make the request to suspend benefits to the director in writing, and must send a copy of the request, including all attachments, simultaneously to the worker and the worker's attorney, if any by registered or certified mail or by personal service;

(E) The insurer's request must include the following information sufficient to show the worker's failure to cooperate:

(i) That the insurer requests suspension of benefits under ORS 656.262(15) and this rule;

(ii) Documentation of the specific actions of the worker or worker's attorney that prompted the request;

(iii) Any reasons given by the worker for failure to comply, or a statement that the worker has not given any reasons;

(iv) A copy of the notice required in (2)(a) of this rule;

(v) All available written documentation of the worker's notice to file a claim, including, but not limited to, a copy of Form 801 and Form 827; and

(vi) All other pertinent information, including, but not limited to, a copy of the claim for a new or omitted condition when that is what the insurer is investigating;

(c) After receiving the insurer's request to suspend benefits, the director will notify all parties that:

(A) The worker's benefits will be suspended in five business days unless:

(i) The worker or the worker's attorney contacts the division as specified in the director's notice and explains how the worker's failure to cooperate was reasonable; or

(ii) The insurer notifies the division that the worker is now cooperating;

(B) The insurer's obligation to accept or deny the claim within 60 days is suspended unless the insurer's request is filed with the division after the 60 days to accept or deny the claim has expired;

(d) If the worker cooperates within five business days of the director's notice under subsection (c), the insurer must notify the director immediately to withdraw the suspension request. Upon receiving the insurer's notification:

(A) The director will notify all the parties of the withdrawal; and

(B) The director may issue an order identifying the dates during which the insurer's obligation to accept or deny the claim was suspended;

(e) If the worker contacts the division and documents the failure to cooperate was reasonable within five business days of the director's notice under subsection (c), the director will not suspend payment of compensation. However, an order may be

issued identifying the dates during which the insurer's obligation to accept or deny the claim was suspended; and

(f) If the worker has not cooperated with the investigation, or has not documented that the failure to cooperate was reasonable within five business days of the director's notice under subsection (c), the director will issue an order suspending all or part of the payment of compensation to the worker:

(A) The suspension of compensation will be effective from the fifth business day after the date of the director's notice under subsection (c), and will remain in effect until the worker reasonably cooperates with the investigation;

(B) If the worker reasonably cooperates with the investigation, the insurer must reinstate the worker's benefits immediately; or

(C) If the worker makes no effort to cooperate within 30 days of the date of the notice, the insurer may deny the claim under ORS 656.262(15) and OAR 436-060-0140(8).

(3) Request for penalty against worker's attorney.

An insurer that believes that a worker's attorney's unwillingness or unavailability to participate in an interview is unreasonable may notify the director in writing and the director will consider assessment of a civil penalty against the attorney of not more than \$1,000.

(a) The worker's attorney must have the opportunity to dispute the allegation before a penalty is assessed.

(b) A copy of the notice must be sent simultaneously to the worker and the worker's attorney. Notice to the division by the insurer must contain the following information:

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

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

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

(4) Failure to comply with this rule.

Failure to comply with the requirements of this rule will be grounds for denial of the insurer's request. Any delay in requesting suspension under section (2) of this rule may result in authorization being denied.

Statutory authority: ORS 656.704 and 656.726(4)

Statutes implemented: ORS 656.262, 656.704, 656.726(4)

Hist: Amended 12/19/22 as WCD Admin. Order 22-067, eff. 1/1/23

Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0137 Vocational Evaluations for Permanent Total Disability Benefits; and Suspension of Compensation

(1) Requests for vocational evaluations.

A worker receiving permanent total disability benefits must attend a vocational evaluation reasonably requested by the insurer or the director.

(2) Allowed number of vocational evaluations.

The insurer may request no more than three separate vocational evaluations without authorization from the director. Insurers that fail to obtain authorization from the director for additional vocational evaluations may be assessed a civil penalty.

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(a) To request authorization the insurer must:

(A) Submit a written request for authorization that includes:

- (i) The reasons for an additional vocational evaluation;
 - (ii) The conditions to be evaluated;
 - (iii) The dates, times, places, and purposes of previous evaluations;
 - (iv) Copies of previous vocational evaluation notification letters to the worker; and
 - (v) Any other information requested by the director;
- (B) Provide a copy of the request to the worker and the worker's attorney, if any.

(b) The director will review the request and determine if additional information is needed.

(A) Upon receipt of a request for additional information from the director, the parties will have 14 days to respond.

(B) If the parties do not provide the requested information, the director will approve or disapprove the request for authorization based on available information.

(c) The director's decision approving or denying more than three vocational evaluations may be appealed to the board within 60 days of the order.

(d) For purposes of determining the number of insurer required vocational evaluations, any evaluations scheduled but not completed are not counted as a statutory vocational evaluation.

(3) Notice to worker.

The insurer must notify the worker of the evaluation at least 10 days before the date of evaluation.

(a) The notice sent for each evaluation, including evaluations that have been rescheduled, must contain the following:

- (A) The name of the vocational assistance provider or facility;
- (B) A statement of the specific purpose for the evaluation;
- (C) The date, time and place of the evaluation;
- (D) The first and last name of the attending physician or authorized nurse practitioner or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;

(E) If applicable, confirmation that the director has approved the evaluation;

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

(G) The following notice:

- (i) In prominent or bold text:

"You must attend this vocational evaluation. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the evaluation. If you do not attend or do not cooperate, or do not have a good reason for not attending, your compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.206 and OAR 436-060. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or the Ombuds Office for Oregon Workers at 1-800-927-1271."

(ii) Effective no later than Oct. 1, 2024, the text in (G)(i) of this subsection must be replaced with the following language in bold and formatted as follows:

You must attend this evaluation.

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

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

- **Do not attend the evaluation,**
- **Do not cooperate with the evaluation, or**
- **Do not have good reason for not attending.**

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 656.206 and Oregon Administrative Rules Chapter 436, division 60**

(b) The insurer may contract with a third party to schedule vocational evaluations. If the third party notifies the worker of a scheduled evaluation on behalf of the insurer, the third party must send the notice on the insurer's stationery and the notice must meet the requirements of this section.

(4) Reimbursements of costs.

The insurer must pay the costs of the vocational evaluation and related services necessary to allow the worker to attend the evaluation, including a reasonable cost of public transportation or use of a private vehicle, and when necessary, a reasonable cost of child care, meals, lodging and other related services. Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, comply with this rule.

(5) Suspension of compensation.

When the worker refuses or fails to attend, or otherwise obstructs, a vocational evaluation reasonably requested by the insurer or the director, the director may suspend the worker's compensation by order, under the following conditions:

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(a) The insurer must send the request for suspension to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service;

(b) The request must include the following information:

(A) That the insurer requests suspension of benefits under ORS 656.206 and OAR 436-060-0137;

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

(C) The dates of any prior vocational evaluations the worker has attended and the names of the vocational assistance provider or facilities, or a statement that there have been no prior evaluations, whichever is appropriate;

(D) A copy of any approvals given by the director for more than three vocational evaluations, or a statement that no approval was necessary, whichever is appropriate;

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

(F) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the vocational evaluation received by the insurer from the worker or the worker's attorney will be sufficient documentation with which to request suspension;

(G) A copy of the letter required in section (3) of this rule and a copy of any written verification received under paragraph (F) of this subsection;

(H) Any other information that supports the request; and

(I) The following notice:

(i) In prominent or bold face type:

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. If the division grants this request, you may lose all or part of your benefits."

(ii) Effective no later than Oct. 1, 2024, the text in (I)(i) of this subsection must be replaced with the following language in bold and formatted as follows:

Notice to worker:

If the Workers' Compensation Division grants this request, you may lose all or part of your 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:

**- [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)**

(c) If the director suspends compensation:

(A) The suspension will be effective from the date the worker fails to attend a vocational evaluation or such other date the director determines is appropriate until the date the worker attends the evaluation;

(B) The worker is not entitled to compensation during or for the period of suspension;

(C) The insurer must assist the worker to meet requirements necessary for the resumption of compensation payments. When the worker has attended the vocational evaluation, the insurer must verify the worker's participation and resume compensation effective the date of the worker's compliance;

(D) The director may modify or set aside the suspension order before or after filing of a request for hearing;

(E) The director may order payment of compensation previously suspended where the director finds the suspension to have been made in error; and

(F) The director may re-evaluate the necessity of continuing a suspension;

(d) If the insurer fails to comply with this rule, the director may deny the request for suspension. Any delay in requesting suspension may result in suspension being denied or the date of suspension being modified; and

(e) A suspension order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the board.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.206

Hist: Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24

Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0140 Acceptance or Denial of a Claim

(1) Claim investigations.

The insurer is required to conduct a "reasonable" investigation based on all available information in determining whether to deny a claim.

(a) A reasonable investigation is whatever steps a reasonably prudent person with knowledge of the legal standards for determining compensability would take in a good faith effort to ascertain the facts underlying a claim, giving due consideration to the cost of the investigation and the likely value of the claim.

(b) In determining whether an investigation is reasonable, the director will only look at information contained in the insurer's

claim record at the time of denial. The insurer may not rely on any fact not documented in the claim record at the time of denial to establish that an investigation was reasonable.

(2) Notice to worker.

The insurer must give the worker written notice of acceptance or denial of a claim within the following time frames:

(a) For claims with a date of injury before Jan. 1, 2002, within 90 days of:

(A) The employer's notice or knowledge of an initial claim;

(B) The insurer's receipt of a [Form 827](#) signed by the worker or the worker's attorney, and the worker's attending physician indicating an aggravation claim; or

(C) Written notice of a new medical condition claim;

(b) For claims with a date of injury on or after Jan. 1, 2002, within 60 days after:

(A) The employer's notice or knowledge of an initial claim;

(B) The insurer's receipt of a Form 827 signed by the worker or the worker's attorney and the worker's attending physician indicating an aggravation claim; or

(C) Written notice of a new medical or omitted condition claim; or

(c) For claims with any date of injury, if the worker challenges the location of an independent medical examination under OAR 436-010-0265 and the challenge is upheld, within 90 days after the employer's notice or knowledge of the claim.

(3) Penalty for untimely acceptance and denials.

The director may assess a penalty under OAR 436-060-0200 against any insurer delinquent in accepting or denying a claim beyond the time frame required under section (2) of this rule.

(4) Notice of acceptance.

A notice of acceptance must comply with ORS 656.262(6)(b) and OAR chapter 438. It must include a current mailing date, be addressed to the worker, be copied to the worker's attorney, if any, and the worker's attending physician, and describe to the worker:

(a) What conditions are compensable;

(b) Whether the claim is disabling or nondisabling;

(c) The Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that the injury is nondisabling by requesting the insurer review the status;

(d) The employment reinstatement rights and responsibilities under ORS chapter 659A;

(e) Assistance available to employers from the Re-employment Assistance Program under ORS 656.622;

(f) That claim related expenses paid by the worker must be reimbursed by the insurer when requested in writing and accompanied by sales slips, receipts, or other reasonable written support, for meals, lodging, transportation, prescriptions and other related expenses. The worker must be advised of the two year time limitation to request reimbursement as provided in

OAR 436-009-0025 and that reimbursement of expenses may be subject to a maximum established rate;

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

(h) That if the worker wants the insurer to accept a claim for a new medical condition, the worker must put the request in writing, clearly identify the condition as a new medical condition, and request formal written acceptance of the condition.

(5) Notice of acceptance, fatal claims.

In the case of a fatal claim, the notice must be addressed "to the estate of" the worker and the requirements of subsection (4)(a) through (h) of this rule must not be included.

(6) Initial, modified, and updated notices of acceptance.

(a) The first acceptance issued on the claim must contain the title "Initial Notice of Acceptance" near the top of the notice. Any notice of acceptance must contain all accepted conditions at the time of the notice.

(b) An insurer must issue a "Modified Notice of Acceptance" (MNOA) when the insurer:

(A) Accepts a new or omitted condition on a nondisabling claim, while a disabling claim is open or after claim closure;

(B) Accepts an aggravation claim;

(C) Changes the disabling status of the claim; or

(D) Amends a notice of acceptance, including correcting a clerical error, except for an error or omission on an "Updated Notice of Acceptance at Closure."

(c) When an insurer closes a claim, it must issue an "Updated Notice of Acceptance at Closure" under OAR 436-030-0015.

(7) Acceptance of new or omitted conditions.

When an insurer accepts a new or omitted condition on a closed claim, the insurer must reopen the claim and process it to closure under ORS 656.262 and 656.267. When a claim is reopened, the notice of acceptance must specify the conditions for which the claim is being reopened.

(8) Notice of denial to worker.

A notice of denial must comply with OAR chapter 438 and the following:

(a) The notice must specify the factual and legal reasons for the denial, including a specific statement indicating if the denial was based in whole or part on an independent medical examination under ORS 656.325;

(b) If the denial was based in whole or part on an independent medical examination under ORS 656.325:

(A) The notice must include one of the following statements, as appropriate:

(i) "Your attending physician agreed with the independent medical examination report";

(ii) "Your attending physician did not agree with the independent medical examination report"; or

(iii) "Your attending physician has not commented on the independent medical examination report"; and

(B) If subparagraph (8)(b)(A)(ii) or (iii) of this rule apply, the notice must include the division's website address and toll-free phone number for the worker's use in obtaining a brochure about the worker requested medical examination.

(c) The notice must inform the worker of the Expedited Claim Service and of the worker's right to a hearing under ORS 656.283; and

(d) If the denial is under ORS 656.262(15), the notice must inform the worker that a hearing may occur sooner if the worker requests an expedited hearing under ORS 656.291.

(9) Notice of denial to provider of medical services and health insurance.

The insurer must send notice of the denial to each medical service provider and provider of health insurance as defined under ORS 731.162 when compensability of any portion of a claim for medical services is denied. The notice must be sent:

(a) At the same time the denial is sent to the worker;

(b) Within 14 days of receipt of any billings from medical providers not previously notified of the denial. The notice must advise the medical provider of the status of the denial; or

(c) Within 60 days of the date when compensability of the claim has been finally determined or when disposition of the claim has been made. The notification must include the results of the proceedings under ORS 656.236 or 656.289(4) and the amount of any settlement.

(10) Payment of compensation.

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

(11) Medical benefits and funeral expenses.

Compensation payable to a worker or the worker's beneficiaries while a claim is pending acceptance or denial does not include:

(a) The costs of medical benefits; or

(b) The cost of final disposition of the body or funeral expenses.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.262, 656.325, and 656.726(4)

Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0141 Claims for COVID-19 or Exposure to SARS-CoV-2

(1) Definitions.

For the purpose of this rule:

(a) "COVID-19" means a disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

(b) "Isolation" means the physical separation and confinement of a person who is infected or reasonably believed to be infected with COVID-19 from nonisolated persons to prevent or limit the transmission of COVID-19 to nonisolated persons.

(c) "Medical service provider" means a person duly licensed to practice one or more of the healing arts.

(d) "Presumptive case" means:

(A) The person has not tested positive for COVID-19;

(B) The person has an acute illness with at least two of the following symptoms: shortness of breath, cough, fever, new loss of smell or taste, or radiographic evidence of viral pneumonia;

(C) There is no more likely alternative diagnosis; and

(D) The person, within the 14 days before illness onset, had close contact with a confirmed case of COVID-19.

(e) "Quarantine" means the physical separation and confinement of a person who has been or may have been exposed to COVID-19 or SARS-CoV-2 and who does not show signs or symptoms of COVID-19, from persons who have not been exposed to COVID-19 or SARS-CoV-2, to prevent or limit the transmission of COVID-19 to other persons.

(f) "SARS-CoV-2" means the strain of coronavirus that causes COVID-19.

(2) Reasonable investigation.

Under OAR 436-060-0140(1), insurers must conduct a "reasonable investigation" before denying any claim. For claims filed on or after Feb. 1, 2021, for COVID-19 or exposure to SARS-CoV-2, in addition to the requirements of OAR 436-060-0140(1), a reasonable investigation must include the steps in subsections (a) through (d) of this section. The steps in subsections (a) through (d) are not required if the claim is denied for procedural reasons not related to the worker's exposure to COVID-19 or SARS-CoV-2 (for example, the claim was filed with the wrong insurer, the insurer did not provide coverage, or the worker is nonsubject).

(a) Investigate whether there was likely exposure to COVID-19 or SARS-CoV-2 that arose out of and in the course of the worker's employment;

(b) Investigate the source of the worker's exposure to COVID-19 or SARS-CoV-2, which must include obtaining a medical or expert opinion, if, before a compensability denial is issued, the worker tests positive for COVID-19 or a medical service provider diagnoses a presumptive case of COVID-19, the insurer is aware of the test results or presumptive diagnosis, and the source of the exposure is unclear;

(c) Determine whether the worker did not work for a period of quarantine or isolation at the direction of a medical service provider, the Oregon Health Authority Public Health Division, a local public health authority as defined in ORS 431.003, or the employer, for purposes of discovering information that may be relevant to the compensability determination; and

(d) Determine whether medical services were required as a result of potential workplace exposure to COVID-19 or SARS-CoV-2, even if the worker ultimately did not test positive for COVID-19.

(3) Auditing and monitoring.

(a) The director shall audit denied claims for COVID-19 or exposure to SARS-CoV-2 that were reported to the director under OAR 436-060-0011 before Oct. 1, 2020, if:

(A) The insurer had reported a total of five or more claims for COVID-19 or exposure to SARS-CoV-2 before Oct. 1, 2020, regardless of whether those claims were accepted or denied; and

(B) The denial is final by operation of law by the date of the audit.

(b) The director shall audit additional denied claims for COVID-19 or exposure to SARS-CoV-2. The specific claims to be audited will be selected based on criteria determined by the director.

(A) Audits of claims filed before Oct. 1, 2020, will focus on whether a reasonable investigation was conducted as required by OAR 436-060-0140(1).

(B) Audits of claims filed on or after Oct. 1, 2020, but before Feb. 1, 2021, will focus on, but not necessarily be limited to, whether the insurer complied with OAR 436-060-0141(2), effective 10/1/2020 (WCD Admin. Order 20-061).

(C) Audits of claims filed on or after Feb. 1, 2021, will focus on, but not necessarily be limited to, whether the insurer complied with section (2) of this rule.

(c) Failure to comply with requirements in ORS chapter 656, OAR chapter 436, or orders of the director may subject an insurer to civil penalties under ORS 656.745(2).

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.262, 656.745

Hist: Amended 1/26/21 as WCD Admin. Order 21-050, eff. 2/1/21

436-060-0147 Worker Requested Medical Examination

(1) Eligibility.

The worker is eligible for a worker requested medical examination if:

(a) The worker has made a timely request for a board hearing on a denial of compensability;

(b) The denial is based on one or more independent medical examination reports; and

(c) The attending physician or authorized nurse practitioner does not concur with the report or reports.

(2) Request for exam.

The worker must submit a request for the exam to the division. A copy of the request must be sent simultaneously to the insurer.

(a) The request must include:

(A) The name, address, and claim identifying information of the worker;

(B) A list of physicians, including names and addresses, who have previously provided medical services to the worker on the

claim, or who have previously provided medical services to the worker related to the claimed conditions;

(C) The date the worker requested a hearing and a copy of the hearing request;

(D) A copy of the insurer's denial letter; and

(E) Documents that demonstrate that the attending physician or authorized nurse practitioner does not concur with the independent medical examination report or reports, if available.

(b) The director will determine the worker is eligible for an exam if the eligibility criteria in section (1) of this rule are met and:

(A) The worker or insurer provides documents that demonstrate that the attending physician or authorized nurse practitioner does not concur with the independent medical examination report or reports; or

(B) The director has not received documents that demonstrate the attending physician or authorized nurse practitioner does or does not concur with the report or reports, and at least 30 days after the worker's request for hearing under subsection (1)(a) of this rule have passed.

(3) Required documentation.

The insurer must send to the director no later than the 14th day following the insurer's receipt of the worker's request, the names and addresses of all physicians or nurse practitioners who have:

(a) Acted as the worker's attending physician or authorized nurse practitioner;

(b) Provided medical consultations or treatment to the worker;

(c) Examined the worker at an independent medical examination requested by the insurer under ORS 656.325; or

(d) Reviewed the worker's medical records on the claim.

(4) Penalty for failure to provide documentation.

Failure to provide the required documentation described in section (3) of this rule in a timely manner may subject the insurer to civil penalties under OAR 436-060-0200.

(5) Selection of physicians.

If the director determines the worker is eligible for the exam, the director will notify all parties in writing of the physician selected, or will provide the worker or the worker's attorney a list of appropriate physicians. If the director provides a list of physicians, the following applies:

(a) The worker's or the worker's attorney's response must be in writing, signed, and delivered to the director within 14 days of the mailing date of the list;

(b) The worker or the worker's attorney may eliminate the name of one physician from the list;

(c) If the worker or the worker's attorney does not respond as provided in this section, the director will select a physician; and

(d) The director will notify the parties in writing of the physician selected.

(6) Scheduling the exam.

The worker or the worker's attorney must schedule the exam with the selected physician, and notify the insurer and the board of the scheduled exam date within 14 days of the date of the director's notice in section (5) of this rule. The exam is not required to take place within the 14-day notification period. An unrepresented worker may consult with the Ombuds Office for Oregon Workers for assistance.

(7) Required medical records.

The insurer must send the physician the worker's complete medical and diagnostic record on the claim and the original questions asked of the independent medical examination physicians no later than 14 days before the date of the scheduled exam. If the diagnostic records are not in the insurer's possession, the insurer must request that the medical provider send the diagnostic records to the selected physician at least 14 days before the scheduled exam.

(8) Exam questions.

The worker, or the worker's attorney, must communicate questions related to the compensability denial in writing to be answered by the physician at the exam to the physician at least 14 days before the scheduled date of the exam. An unrepresented worker may consult with the Ombuds Office for Oregon Workers for assistance.

(9) Physician's response.

Upon completion of the exam the physician must address the original independent medical examination questions and the questions from the worker or the worker's attorney under section (8) of this rule and send the report to the worker's attorney, if any, or the worker, and the insurer within 14 days.

(10) Payment of physician.

The insurer must pay the physician selected under this rule in accordance with OAR 436-009. Medical services to workers must be delivered in accordance with OAR 436-010.

(11) Failure to attend exam.

If the worker does not attend the scheduled worker requested medical exam, the insurer must pay the physician for the missed exam under OAR 436-009-0010(13). The insurer is not required to pay for another exam unless the worker did not attend the missed examination for reasons beyond the worker's reasonable control.

(12) Reimbursement for services.

The insurer must reimburse the worker for all necessary related services under ORS 656.325(1).

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.325(1)

Hist: Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24

436-060-0150 Timely Payment of Compensation

(1) General.

Benefits are considered paid when addressed to the last known address of the worker or beneficiary and deposited in the U.S. Mail, or when funds are transferred to a financial institution for deposit in the worker's or beneficiary's account by approved electronic equivalent.

(2) Saturday, Sunday, or legal holidays.

Payments due on a Saturday, Sunday, or legal holiday under ORS 187.010 and 187.020 may be paid on the last working day before, or the first working day after, the Saturday, Sunday, or legal holiday. Subsequent payments may revert back to the payment schedule in place before the Saturday, Sunday, or legal holiday.

(3) Withheld compensation.

Compensation withheld under ORS 656.268(13) and (14), and ORS 656.596(2), will not be considered late if the insurer notifies the worker in writing why benefits are being withheld and the amount that must be offset before any further benefits are payable.

(4) Timely payment of temporary disability.

Insurers must timely process the first payment of temporary disability compensation. The first payment of temporary disability on a claim must also include all temporary disability benefits due as of the date of payment, unless there is a reasonable basis to exclude those benefits at the time the payment issued. The director may assess a penalty under OAR 436-060-0200 against an insurer that does not make the first payment of temporary disability under the time frames of this section, or does not accurately report timeliness of first payment information.

(a) The payment of temporary disability benefits must be made no later than the 14th day after:

(A) The date of the employer's notice or knowledge of the claim and of the worker's disability, if the attending physician or authorized nurse practitioner has authorized temporary disability compensation. Temporary disability accrued before the date of the employer's notice or knowledge of the claim is due within 14 days of claim acceptance;

(B) The date the attending physician or authorized nurse practitioner authorizes temporary disability, if the authorization is more than 14 days after the date of the employer's notice or knowledge of the claim and of the worker's disability;

(C) The start of authorized vocational training under ORS 656.268(10), if the insurer has previously closed the claim;

(D) The date the insurer receives medical evidence supported by objective findings that shows the worker is unable to work due to a worsening of the compensable condition under ORS 656.273;

(E) The date of any director's order, including, but not limited to, a reconsideration order, that orders payment of temporary disability. If the insurer has appealed a reconsideration order, the appeal stays payment of temporary disability benefits except those that accrue from the date of the order, under ORS 656.313;

(F) The date of a notice of claim closure issued by the insurer that finds the worker entitled to temporary disability;

(G) The date a notice of closure is set aside by a reconsideration order;

(H) The date any litigation authorizing retroactive temporary disability becomes final. Temporary disability accruing from the date of the order must begin no later than the 14th day after

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the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the board is the signature date, and from the courts, it is the date of the appellate judgment;

(I) The date the director refers a claim to the insurer for processing under ORS 656.029;

(J) The date the director refers a noncomplying employer claim to an assigned claims agent under ORS 656.054;

(K) The date a claim disposition agreement is disapproved by the Worker's Compensation Board or administrative law judge, if temporary disability benefits are otherwise due;

(L) The date the director designates a paying agent under ORS 656.307;

(M) The date a claim is reclassified from nondisabling to disabling, if temporary disability is due and payable; or

(N) The date an insurer voluntarily rescinds a denial of a disabling claim.

(b) Subsequent payments of temporary disability benefits must be made:

(A) At least once each 14 days, and include all benefits due for the period ending no more than seven days before the payment date; or

(B) In accordance with the employer's payroll schedule and pay period. If temporary disability benefits are paid under this paragraph, the insurer's claim file must include written documentation of the payroll schedule and pay period before the payments are issued.

(5) Timely payment of permanent disability.

(a) The first payment of permanent disability must be paid no later than the 30th day after:

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

(B) The date of any litigation order that orders payment of permanent total disability. Permanent total disability benefits accruing from the date of the order must begin no later than the 30th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the board is the signature date, and from the courts, it is the date of the appellate judgment;

(C) The date of any director's order, including, but not limited to, a reconsideration order, that orders payment of compensation for permanent disability;

(D) The date any litigation order authorizing permanent partial disability becomes final;

(E) The date a claim disposition agreement is disapproved by the board or administrative law judge, if permanent disability benefits are otherwise due; or

(F) The date authorized training ends if the worker is medically stationary and any previous award remains unpaid, under ORS 656.268(10) and OAR 436-060-0040(3).

(b) Subsequent payments of permanent disability must be made on a regular and predictable monthly schedule.

(A) The insurer may adjust the monthly payment schedule, but must inform the worker or beneficiary before making the adjustment.

(B) No payment period may exceed one month without the director's approval.

(6) Timely payment of death benefits.

(a) Payment of bills submitted under OAR 436-060-0075(1) must be made no later than the 30th day after the date of the insurer's receipt the bill, or the date of claim acceptance, whichever is later.

(b) The first payment of monthly benefits to eligible beneficiaries under OAR 436-060-0075 must be paid no later than the 30th day after:

(A) The date of a notice of acceptance issued by the insurer; or

(B) The date of any litigation order that orders death benefits. Death benefits accruing from the date of the order must begin no later than the 30th day after:

(i) The signature date of an order from the board; or

(ii) The date of an appellate judgment from the courts.

(c) Subsequent payments of monthly benefits to eligible beneficiaries under OAR 436-060-0075 must be made on a regular and predictable schedule, subject to the following:

(A) The insurer may adjust the monthly payment schedule, but must inform the beneficiary before making the adjustment; and

(B) No payment period may exceed one month without the director's approval.

(d) Notwithstanding subsection (c), the insurer may make a payment in advance with the consent of the beneficiary.

(e) Payment of monthly benefits due to a worker's death during a period of permanent total disability under OAR 436-060-0075(7) must follow the monthly schedule established under subsection (5)(b) of this rule.

(7) Notice to worker or beneficiary regarding payments.

The insurer must provide an explanation in writing to the worker or beneficiary when the benefit amount, time period covered, or payment schedule changes, and must:

(a) Notify the worker or beneficiary in writing of the specific purpose and the time period covered by each payment of temporary disability benefits; and

(b) Notify the worker or beneficiary in writing of the specific purpose of the payment, the schedule of future payments, and the time period each payment will cover with the first payment of permanent disability or death benefits. The insurer is not required to provide an explanation in writing with each subsequent permanent disability or death benefit payment.

(8) Maintenance of records.

The insurer must maintain records of compensation paid for each claim in which benefits are due and payable.

(9) Request for reimbursement.

If the worker submits a request for reimbursement, the insurer must respond as required under OAR 436-009-0025(1).

(10) Claim disposition agreements.

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Any amounts due under a claim disposition agreement must be paid no later than the 14th day after the board or administrative law judge provides notice of its approval under OAR 438-009-0028, unless otherwise stated in the agreement.

(11) Claims under other jurisdictions.

When a worker has a claim under the workers' compensation law of another state, territory, province or foreign nation for the same injury or occupational disease as the claim filed in Oregon:

(a) The worker is entitled to the full amount of compensation due under Oregon law;

(b) The total amount paid or awarded under the other jurisdiction's law must be credited against the compensation due under Oregon law;

(c) If Oregon compensation is more than the compensation paid or awarded under the other jurisdiction's law, or compensation paid the worker under another law is recovered from the worker, the insurer must pay any unpaid compensation to the worker up to the amount required by the claim under Oregon law;

(d) Upon learning that the worker has a claim under the jurisdiction of another workers' compensation law, the insurer must request written documentation of the amount paid or awarded to the worker; and

(e) Payment under this section is due within 14 days of receipt of written documentation supporting the underpayment of Oregon compensation.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.126, 656.204, 656.208, 656.262(4), 656.268(10), 656.273, 656.278, 656.289, 656.307, and 656.313
Hist: Amended 12/19/22 as WCD Admin. Order 22-067, eff. 1/1/23
Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0153 Electronic Payment of Compensation

(1) General.

Benefits may be paid through a direct deposit system, automated teller machine card or debit card, or other means of electronic transfer if the worker voluntarily consents.

(a) Except as provided under (1)(c) of this rule, an insurer must obtain the worker's consent before initiating electronic payments. The consent may be written or verbal. The insurer must provide the worker a written confirmation when consent is obtained verbally.

(b) An employer making payments under OAR 436-060-0020(1) may assume the worker consents to having benefits paid through a direct deposit system if that is the method the employer usually uses to pay the worker's wages.

(c) A self-insured employer paying benefits may assume the worker consents to having benefits paid through a direct deposit system if that is the method the employer usually uses to pay the worker's wages.

(d) The worker may discontinue receiving electronic payments by notifying the insurer or employer in writing.

(2) Cardholder agreement for ATM or debit cards.

The worker must receive a copy of the cardholder agreement outlining the terms and conditions under which an automated teller machine card or debit card has been issued before or at the time the initial electronic payment is made.

(3) Instrument of payment.

The instrument of payment must be negotiable and payable to the worker for the full amount of the benefit paid, without cost to the worker.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.262(4) and 84.013
Hist: Amended 12/19/22 as WCD Admin. Order 22-067, eff. 1/1/23

436-060-0155 Penalty to Worker for Untimely Processing

(1) General.

If the insurer unreasonably delays or unreasonably refuses to pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim:

(a) The director may require the insurer to pay:

(A) A penalty, payable to the worker, of up to 25 percent of the amounts then due, determined by the matrix attached to these rules in Appendix "B." When there are no "amounts then due" upon which to assess a penalty, no penalty will be issued under this rule; and

(B) A fee to the worker's attorney under ORS 656.262(11) and OAR 436-001-0420.

(b) For the purpose of this rule, and the matrix attached to these rules in Appendix "B," a "violation" is:

(A) The late payment or the nonpayment of any single payment due;

(B) A continuous underpayment, such as with yearly cost of living increases for temporary disability compensation. In the case of a continuous underpayment, all prior underpayments will be considered as one violation, regardless of when the first underpayment occurred; or

(C) The late issuance of an acceptance or denial notice under OAR 436-060-0140(2).

(2) Requests for penalties and attorney fees.

Requests for penalties and attorney fees under this rule must:

(a) Be made in writing;

(b) State, in the request, what benefits have been delayed or remain unpaid; and

(c) Be mailed or delivered to the division within 180 days of the date of the alleged violation. For the purpose of this rule, the date of the alleged violation is:

(A) For the late payment or nonpayment of any single payments, the date payment was due;

(B) For a continuous underpayment, the date of the last underpayment; or

(C) For a late issuance of an acceptance or denial notice, the date the notice was due under OAR 436-060-0140(2).

(3) Required response from the insurer.

When notified by the director that additional amounts may be due to the worker as a penalty under this rule:

(a) The insurer must respond in writing to the division:

(A) The response must include a reason for the delay, and any additional information or documentation requested by the director;

(B) The response must be mailed or delivered to the division within 14 days of the mailing date of the director's inquiry letter; and

(C) Copies of the response, including any attachments, must be simultaneously sent to the worker and the worker's attorney, if any;

(b) If the insurer fails to meet the requirements of this section, the director may assess a civil penalty under OAR 436-060-0200.

(4) Jurisdiction over proceedings.

The director has exclusive jurisdiction when the assessment and payment of penalties and attorney fees described in ORS 656.262(11) is the sole issue between the parties.

(a) If the director receives a request for penalties and attorney fees under this rule, and is aware that a hearing has been requested before the board on other issues, the director may transfer the request to the board. Factors the director will consider in determining whether to transfer the request include, but are not limited to, the status of the hearing and the date set for the hearing. The determination of whether to transfer a request to the board is solely within the authority of the director.

(b) If the director has not been made aware of the proceeding before the board and issues a penalty order that becomes final, the director's penalty will stand.

(5) Timely payment of penalties.

Penalties ordered under this rule must be paid to the worker no later than the 30th day after the date of the order, unless the order is appealed. If the order is appealed and later upheld, the penalty will be due within 14 days of the date the order upholding the penalty becomes final. If the insurer does not pay penalties in a timely manner the insurer will be subject to civil penalties under OAR 436-060-0200.

(6) Dispute resolution.

Disputes regarding unreasonable delay or unreasonable refusal to pay compensation, attorney fees or costs, or unreasonable delay in acceptance or denial of a claim may be resolved by the parties.

(a) In cases where the director has exclusive jurisdiction under section (4) of this rule, and the violations occurred within the last 180 days as described in subsection (2)(c) of this rule, then the parties must submit a stipulation to the division for approval. The stipulation must specify:

(A) The benefits, attorney fees, or costs delayed and the amounts;

(B) The time periods involved;

(C) If applicable, the name of the medical providers and the dates of services relating to medical bills;

(D) The amount of the penalty not to exceed 25 percent of the amounts then due under ORS 656.262(11)(a); and

(E) The attorney fees, if applicable.

(b) Any other agreements between the parties to pay a penalty or attorney fee must have a stipulation approved by the director to be acknowledged as a violation as it applies to the matrix in Appendix "B" of these rules.

(c) Payment of a penalty due under this section is due within 14 days after the date the director approves the stipulation, unless otherwise stated in the stipulation. If the insurer does not pay penalties in a timely manner the insurer will be subject to civil penalties under OAR 436-060-0200.

Statutory authority: ORS 656.262(11), 656.704, 656.726(4), and 656.745

Statutes implemented: ORS 656.262(11), 656.704, and 656.745

Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0160 Use of Sight Draft to Pay Compensation Prohibited

Insurers may not use a sight draft to pay any benefits or payments due a worker or beneficiary under ORS chapter 656.

Statutory authority: 656.726(4)

Statutes implemented: 656.726(4)

Hist: Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17

436-060-0170 Recovery of Overpayment of Benefits

(1) Benefits paid a worker.

An insurer may recover overpayment of benefits paid to a worker as specified by ORS 656.268(12), (13), (14), and (16), unless authority is granted by an administrative law judge or the board.

(2) Benefits due a worker.

An insurer may recover an overpayment from any benefits currently due on any claim the worker has with that insurer. The insurer must explain in writing the reason, the amount, and the method of recovery to the worker and the worker's attorney, if any, or to the worker's beneficiaries.

(3) Permanent partial disability offsets.

When overpaid benefits are offset against monthly permanent partial disability award payments, the insurer must recover the benefits from the total amount of the award. The insurer must pay out the remainder of the award at 4.35 times the temporary total disability rate, or at least \$108.75, starting with the first month's payment.

(4) Supplemental disability benefits.

The director, through its assigned processing administrator described under OAR 436-060-

0035(2)(d), may recover overpayments of supplemental disability benefits under the same conditions provided under ORS 656.268(12), (13), (14), and (16), or may require the insurer

to do so. If the insurer recovers an overpayment on behalf of the assigned processing

administrator, the insurer must reimburse the assigned processing administrator.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.268(13), (14), and (16) (OL2022, ch.73, sections 4 & 5)

Hist: Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24

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**Administrative
Order No.
24-053**

Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0180 Designation and Responsibility of a Paying Agent

(1) For the purpose of this rule:

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

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

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

(d) "**Earliest claim**" means the earliest date of:

(A) A written request for compensation from a subject worker or someone on the worker's behalf; or

(B) The subject employer's notice or knowledge of the compensable injury.

(2) General.

The director will designate by order which insurer must pay a claim if the employers and insurers admit that the claim is otherwise compensable, and where there is an issue regarding:

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

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

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

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

(3) Own motion claims.

With the consent of the board, own motion claims under ORS 656.278(1) are subject to this rule.

(4) Determination of compensability.

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

(a) For the purposes of this rule, insurers identified in a potential responsibility dispute under ORS 656.307 must, upon request, share claim related medical reports and other information pertinent to the injury without charge in order to expedite claim processing.

(b) The act of the worker applying for compensation benefits from any employer identified as a party to a responsibility dispute constitutes authorization for the involved insurers to share the pertinent information in accordance with the criteria and restrictions provided in OAR 436-060-0017 and 436-010-0240.

(c) Copies of claims documents must be mailed under the time frames established in OAR 436-060-0017(5).

(d) An insurer that shares information under this rule bears no legal liability for disclosure of the information.

(5) Notification of affected insurers.

Upon learning of any of the issues described in section (2) of this rule, the insurer must immediately notify any other affected insurers of the situation. Such notice must identify the compensable injury and include a copy of all medical reports and other information pertinent to the injury. The notice must identify each period of exposure that the insurer believes responsible for the compensable injury by the following:

(a) Name of employer;

(b) Name of insurer;

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

(d) Claim number, if assigned.

(6) Request for designation of a paying agent.

Upon deciding that the responsibility for an otherwise compensable injury cannot be determined, the insurer must request designation of a paying agent from the director in writing and mail a copy of the request to the worker and the worker's attorney, if any.

(a) The insurer may not attach the request to, or include the request in, any form or report the insurer is required to submit under OAR 436-060-0011 or in the denial letter to the worker required by OAR 436-060-0140.

(b) The request, or agreement to designation of a paying agent, is not an admission that the insurer is responsible for the compensable injury; it is solely an assertion that the injury is compensable against a subject Oregon employer.

(c) The insurer's written request must contain the following information:

(A) Identification of the compensable injuries or occupational diseases;

(B) That the insurer is requesting designation of a paying agent under ORS 656.307;

(C) That the insurer acknowledges the claim is otherwise compensable;

(D) That responsibility is the only issue;

(E) Identification of the specific claims or exposures involved by:

(i) Employer;

(ii) Insurer;

(iii) Date of injury or specific period of exposure; and

(iv) Claim number, if assigned;

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

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

(H) The worker's average weekly wage, as calculated under OAR 436-060-0025; and

(I) The earliest claim date.

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(d) The director will not designate a paying agent when:

(A) It has not been determined if the injury is compensable against a subject Oregon employer;

(B) An insurer included in the question of responsibility opposes designation of a paying agent because it has received no claim; or

(C) The 60 day appeal period of a denial expired and:

(i) No request for hearing had been received by the board; or

(ii) No request for a designation of paying agent order had been received by the director.

(7) Failure to respond to request for clarification.

When notified by the director that there is a reasonable doubt as to the status of the claim or intent of a denial, the insurer must provide written clarification to the director, the worker, the other insurers involved and other interested parties within 14 days of the insurer's date of receipt of the notification. If an insurer fails to respond timely or provides an inadequate response (e.g., failing to answer specific questions or provide requested documents), the director may assess a civil penalty under OAR 436-060-0200.

(8) Insurer responsibilities.

Insurers receiving notice from the director of a worker's request for designation of a paying agent must immediately process the request in accordance with sections (4) through (6) of this rule.

(9) Factors for designation.

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

(A) The claim with the lowest temporary total disability rate;

(B) If the temporary total disability rates and the dollar rates of permanent partial disability in Bulletin 111 are the same, the earliest claim;

(C) If there is no temporary disability or the temporary total disability rates are the same, but the dollar rates of permanent partial disability in Bulletin 111 are different, the claim with the lowest dollar rate of permanent partial disability;

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

(E) If one claim is under own motion jurisdiction, that claim, even if it is not the claim with the lowest temporary total disability rate; and

(F) If more than one claim is under own motion jurisdiction, the own motion claim with the lowest temporary total disability rate.

(b) If the claim with the lowest compensation cannot be determined under (a) of this

section, the director may consider other information to designate a paying agent.

(10) Referral to the Worker's Compensation Board.

By copy of its order, the director will refer the matter to the board to set a proceeding under ORS 656.307 to determine which insurer is responsible for paying benefits to the worker.

(11) Responsibilities of designated paying agent.

The designated paying agent must process the claim as an accepted claim through claim closure under OAR 436-030-0015 unless it is relieved of the responsibility by an order of the administrative law judge or resolution through mediation or arbitration under ORS 656.307(6).

(a) The parties to an order under this section may not settle any part of a claim under ORS 656.236 or 656.289, except to resolve the issue of responsibility, unless prior approval and agreement is obtained from all potential responsible insurers.

(b) Resolution of a dispute by mediation or arbitration by a private party cannot obligate the Consumer and Business Services Fund without the director's prior approval.

(c) The Consumer and Business Services Fund is not obligated when one party declines to participate in a legitimate settlement conference under an ORS 656.307 order.

(d) Compensation paid under the order must include all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries. The payment of temporary disability due must be for periods subsequent to periods of disability already paid by any insurer.

(12) Change in compensability or claims status.

After a paying agent is designated, if any of the insurers determine compensability may be an issue at hearing, the insurer must notify the director.

(a) Any insurer must notify the director and all parties to the order of any change in claim acceptance status after the designation of a paying agent.

(b) When the director receives notification of a change in the acceptance of a claim or notification that compensability is an issue after designation of a paying agent, the director will order termination of any further benefits due from the original order designating a paying agent.

Statutory authority: ORS 656.307, 656.726(4), and 656.745
Statutes implemented: ORS 656.307, 656.308, and 656.745
Hist: Amended 12/13/21 as WCD Admin. Order 21-056, eff. 1/1/22
Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0190 Monetary Adjustments among Parties and Department of Consumer and Business Services

(1) General.

An order of the director under ORS 656.307 and OAR 436-060-0180 applies only to the period before the order of the administrative law judge determining the responsible paying party. Payment of compensation made after the order may not be recovered from the Consumer and Business Services Fund, unless the director concludes payment was made before the administrative law judge's order was received by the paying

agent designated under OAR 436-060-0180. After the administrative law judge's order, any necessary monetary adjustments must be made under OAR 436-060-0195.

(2) Determination of benefits paid.

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

(3) Reimbursement of nonresponsible insurers.

The responsible insurer must reimburse any nonresponsible insurers for compensation the nonresponsible insurer paid that the responsible insurer is responsible for, but has not already paid, within 30 days of receiving enough information to determine the benefits paid and the relationship to the conditions involved. Any balance remaining due to the worker, medical providers or others must be paid in a timely manner under OAR 436-009 and 436-060-0150. Payment of compensation that results in duplicate payment to the worker, medical providers or others as a result of failing to contact the nonresponsible insurer does not release the responsible insurer from the requirement to reimburse any nonresponsible insurers for its costs.

(4) Direction of unresolved adjustments.

The director may direct any necessary monetary adjustment between the parties that is not otherwise ordered by the administrative law judge or voluntarily resolved by the parties. The director will not order an insurer to pay compensation above that required by law, as it relates to the insurer's claim, except in the situation described in section (3) of this rule. Any insurer that fails to make monetary adjustments within 30 days of an order by the director may be subject to civil penalties under OAR 436-060-0200. Only compensation paid as a result of an order by the director under OAR 436-060-0180 and consistent with this rule is recoverable from the Consumer and Business Services Fund when such compensation is not reimbursed to the nonresponsible insurer by the responsible insurer.

(5) Unnecessary costs.

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

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.307(3)
Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

436-060-0195 Miscellaneous Monetary Adjustments among Insurers

(1) General.

The director may order monetary adjustments between insurers when a worker has a right to compensation, but there is a dispute between insurers that does not fall under the director's authority in ORS 656.307 and OAR 436-060-0190.

(a) When any litigation on the issues in question is final, insurers must make any necessary monetary adjustments between themselves, consistent with the determination of coverage for compensation paid to the worker, medical providers, and others for which they are responsible, within 30 days of receiving enough information to determine the benefits paid and the relationship to the conditions involved.

(b) Any balance due after making such adjustments must be paid in a timely manner to the worker, medical providers and other parties under OAR 436-009 and 436-060-0150.

(c) Any failure to obtain reimbursement from an insurer under this rule is not recoverable from the Consumer and Business Services Fund.

(2) Obligation to process claims.

The director may direct any necessary monetary adjustment between parties, but will not order an insurer to pay compensation above that required by law, as it relates to the insurer's claim, except when an insurer unduly compensates a worker while having knowledge such compensation has already been paid by another insurer. However, each insurer has its own independent obligation to process its claim and pay compensation due until the claim is either accepted or denied. When notified by the director that a dispute over monetary adjustment exists the insurer must provide a written response to questions or issues raised, including supporting documentation, to the division, the other insurers involved and other interested parties within 21 days of the mailing date of the notification.

(3) Failure to make adjustments.

Failure to respond to the director's inquiries or make monetary adjustments within 30 days of an order by the director will subject the insurer to civil penalties under OAR 436-060-0200.

(4) Unnecessary costs.

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

Statutory authority: ORS 656.704, 656.726(4), and 656.745
Statutes implemented: ORS 656.704, 656.726(4), and 656.745
Hist: Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17

436-060-0200 Assessment of Civil Penalties

(1) Penalties for inducing failure to report claims.

The director will assess a civil penalty under ORS 656.745(1) against an employer or insurer that intentionally or repeatedly induces workers to fail to report accidental injuries, causes employees to collect accidental injury claims as off-the-job injury claims, persuades workers to accept less than the compensation due or makes it necessary for workers to resort to proceedings against the employer to secure compensation due.

For the purpose of this section:

(a) **"Intentionally"** means the employer or insurer acted with a conscious objective to engage in the conduct or cause any result described in this section; and

(b) **"Repeatedly"** means more than once in any 12-month period.

(2) Penalties for failure to comply with statutes, rules, and orders.

The director may assess a civil penalty under ORS 656.745(2) against an employer or insurer that violates ORS chapter 656, OAR chapter 436, or orders of the director regarding reports or other requirements necessary to carry out the purposes of ORS chapter 656. Except as provided in ORS 656.780, the director may assess a civil penalty against a service company only for claims processing violations identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an employer, insurer, or service company identified in an annual audit.

(3) Penalties for failure to meet time frame requirements.

The director may assess a civil penalty under ORS 656.745(2) against an employer or insurer that does not meet the time frame requirements in OAR 436-060-0010, 436-060-0011, 436-060-0017, 436-060-0018, 436-060-0030, 436-060-0060, 436-060-0140, 436-060-0147, 436-060-0155 and 436-060-0180. The director may assess a civil penalty under ORS 656.745(2) against a service company that does not meet the time frame requirements, only for violations identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an employer, insurer, or service company identified in an annual audit.

(4) Penalties for use of sight draft to pay compensation.

The director may assess a civil penalty under ORS 656.745(2) against an insurer that willfully violates OAR 436-060-0160.

(5) Penalties for inaccurate reporting of first payment timeliness.

The director may assess a civil penalty under ORS 656.745(2) against an insurer that does not accurately report timeliness of first payment information to the division. The director may assess this civil penalty against the service company processing the insurer's claims if the violations were identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an insurer or service company identified in an annual audit. For the purposes of this section, a violation consists of each situation in which a first payment was reported to have been made timely, but was found upon audit to have actually been late.

(6) Penalties for failure to comply with claims processing requirements.

Notwithstanding section (3) of this rule, the director may assess civil penalties under ORS 656.745(2) against an employer, insurer, or service company for each violation of the

claims processing requirements of ORS chapter 656, OAR chapter 436, or orders of the director. For the purpose of this section, the statutory claims processing requirements include but are not limited to, ORS 656.202, 656.210, 656.212, 656.228, 656.234, 656.236, 656.245, 656.262, 656.263, 656.264, 656.265, 656.268, 656.273, 656.307, 656.313, 656.325, and 656.331.

(7) Penalties for misrepresentation to obtain claims records.

The director may assess a civil penalty of \$1,000 against any employer or insurer that misrepresents itself in any manner to obtain workers' compensation claims records from the director, or that uses such records in a manner contrary to these rules. In addition, the director may suspend or revoke:

(a) An employer's or insurer's access to workers' compensation claims records for such time as the director may determine; or

(b) Any other person's access to workers' compensation claims records if the director determines they have misrepresented themselves or used records in a manner contrary to these rules.

(8) Performance audits.

Insurers will be subject to periodic performance audits. Civil penalties may be issued for each area where the insurer's performance falls below the acceptable standards set forth in the rules and orders of the director.

(9) Considerations for assessing penalties.

In arriving at the amount of penalty under this rule, the director may consider, but is not limited to:

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

(b) The ratio of the volume of violations to the average volume of violations for all insurers; and

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

(10) Penalty to worker's attorney for failure to cooperate with insurer's investigation.

The director may assess a civil penalty not to exceed \$1,000 against a worker's attorney that is unreasonably unwilling or unavailable to participate in an insurer's interview as required by ORS 656.262(14).

Statutory authority: ORS 656.704 and 656.726(4)

Statutes implemented: ORS 656.202, 656.210, 656.212, 656.228, 656.234, 656.236, 656.245, 656.262, 656.263, 656.264, 656.265, 656.268, 656.273, 656.307, 656.313, 656.325, 656.331, 656.704, 656.726(4), and 656.745

Hist: Amended 12/19/22 as WCD Admin. Order 22-067, eff. 1/1/23

436-060-0400 Penalty and Attorney Fee for Untimely Payment of Disputed Claims Settlement

(1) Right to request penalties and attorney fees.

If the insurer fails to pay amounts due on a disputed claims settlement within five business days of receipt of notice from the worker that the payment is late, the worker or worker's attorney may request penalties and attorney fees.

(2) Requirements for requests.

Requests for penalties and attorney fees under this rule must be in writing, state what payments were delayed or remain unpaid, and be mailed or delivered to the division within 180 days of the date of notice to the insurer. In order to be awarded an attorney fee the attorney must submit a signed, current retainer agreement.

(3) Required response from the insurer.

When notified by the director that a penalty or attorney fees have been requested under this rule, the insurer must respond in writing to the division.

(a) The response must include any information or documentation requested by the director.

(b) The response must be mailed or delivered to the division within 14 days of the date of the director's inquiry letter; and

(c) Copies of the response, including any attachments, must be sent simultaneously to the worker and the worker's attorney, if any.

(4) Failure to respond.

If the insurer fails to meet the requirements of section (3) of this rule, the director may assess additional civil penalties under OAR 436-060-0200.

(5) Penalty and fee amounts.

The penalty and fee will be based on the amounts allocated to the worker and the attorney in the settlement agreement as prescribed in ORS 656.262(12)(b). Penalties will be issued in accordance with the matrix set forth in Appendix "C."

(6) Timely payment of penalties.

Penalties and attorney fees ordered under this rule must be paid to the worker and attorney no later than the 30th day after the date of the order, unless the order is appealed. If the order is appealed and later upheld, the penalty and attorney fee will be due within 14 days of the date the order upholding the penalty becomes final. Failure to pay penalties and attorney fees in a timely manner may subject the insurer to civil penalties under OAR 436-060-0200.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.262
Hist: Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17

436-060-0500 Reimbursement of Supplemental Disability for Workers with Multiple Jobs at the Time of Injury

(1) General.

When an insurer elects to pay supplemental disability due a worker with multiple jobs at the time of injury, the director will reimburse the supplemental amount quarterly, after receipt and approval of documentation of compensation paid by the insurer or service company. The director will reimburse the insurer, in care of the service company, if applicable.

(2) Requests for reimbursement.

Requests for reimbursement must be submitted on [Form 3504](#), "Supplemental Disability Benefits Quarterly Reimbursement Request," and must include at least:

(a) Identification and address of the insurer responsible for processing the claim;

(b) The worker's name, WCD file number, date of injury, Social Security number (if known), and the insurer claim number;

(c) Whether the claim is disabling or nondisabling;

(d) The primary and secondary employers' legal names;

(e) The primary and secondary employers' policy numbers;

(f) The weekly wage of all jobs at the time of the injury separated by employer;

(g) The start and end dates for the periods of supplemental disability due and payable to the worker;

(h) The amount of supplemental disability paid for the periods in subsection (g);

(i) The quarter and year in which the payment was made;

(j) A signed payment certification statement verifying the payments; and

(k) Any other information the director requires.

(3) Administrative fee.

In addition to the supplemental disability reimbursement, the director will pay the insurer an administrative fee based on the annual claim processing administrative cost factor, as published in [Bulletin 316](#).

(4) Repayment of invalid or incorrect payments.

The director may require the insurer to repay reimbursements made for invalid or incorrect payments. An invalid or incorrect payment may be identified at any time, including during an audit by the director, or when the insurer or assigned processing administrator identifies that supplemental disability benefits have been overpaid.

(a) The director may periodically audit the insurer's files to validate the amount reimbursed.

(b) Invalid amounts include, but are not limited to:

(A) Payments exceeding statutory amounts due to the insurer, excluding reasonable overpayments, as determined by the director;

(B) Compensation paid as a result of untimely or inaccurate claims processing;

(C) Payments of compensation that were not documented as required by OAR 436-050; or

(D) Amounts in a third-party recovery that result in overpayment.

(5) Benefits due workers of a noncomplying employer.

Supplemental disability benefits due subject workers of a noncomplying employer as defined in ORS 656.052 are not eligible for separate reimbursement under this rule, but remain a cost recoverable from the employer as provided by ORS 656.054(2).

(6) Claim disposition agreements and stipulated claims settlements.

Claim dispositions agreements or stipulated claims settlements, under ORS 656.236 or 656.289, that include amounts for supplemental disability benefits due to multiple jobs, are not eligible to receive reimbursement from the

Workers' Benefit Fund unless they receive written confirmation from the director before the disposition or settlement is approved by the Worker's Compensation Board.

(a) To receive written confirmation of a proposed disposition or settlement, the insurer must submit a request to the division. The request for written confirmation must include:

(A) A copy of the proposed disposition or settlement that specifies the exact amount of the proposed contribution to be made from the Workers' Benefit Fund;

(B) A statement from the insurer indicating how the amount of the contribution was calculated; and

(C) Any other information required by the director.

(b) The director will not confirm the disposition for reimbursement if the proposed contribution exceeds a reasonable projection of that claim's future liability to the Workers' Benefit Fund.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.210

Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

Amended 6/7/24 as Admin. Order 24-053, eff. 7/1/24

436-060-0510 Reimbursement of Permanent Total Disability Benefits from the Workers' Benefit Fund

(1) General.

The insurer may request reimbursement of permanent total disability benefits paid after the date of the notice of closure under ORS 656.206(6)(a).

(2) Requirements for requests.

Requests for reimbursement must be filed within one year of the mailing date of the final order upholding the notice of closure and include:

(a) Sufficient information to identify the insurer and the injured worker;

(b) The net dollar amount of permanent total disability benefits paid. "Net dollar amount" means the total compensation paid less any recoveries, including, but not limited to, third party recoveries or amounts reimbursable from the Retroactive Program or Reopened Claims Program; and

(c) A statement certifying that payment has been made.

(3) Moneys due under Retroactive or Reopened Claims Programs.

If any of the moneys are due under the Retroactive Program or Reopened Claims Program, any reimbursement request must be submitted under OAR 436-075 or OAR 436-045.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.206 and 656.605

Hist: Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17

**OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
CLAIMS ADMINISTRATION**

**Administrative
Order No.
24-053**

APPENDIX "A"

436-060-0017 Matrix for Assessing Penalties

VIOLATION NUMBER

Number of days late	1	2	3	4	5+
1-7	\$0	\$100	\$250	\$500	\$1,000
8-14	\$100	\$250	\$500	\$1,000	\$1,000
15-21	\$250	\$500	\$1,000	\$1,000	\$1,000
22+	\$500	\$1,000	\$1,000	\$1,000	\$1,000

APPENDIX "B"

436-060-0155 Matrix for Assessing Penalties

VIOLATION NUMBER

Number of days late	1	2	3	4
1-2	0%	10%	20%	25%
3-7	5%	15%	25%	
8-14	10%	20%	25%	
15-21	15%	25%		
22 +	25%			

APPENDIX "C"

436-060-0400 Matrix for Assessing Penalties

**SETTLEMENT PROCEEDS ALLOCATED TO
WORKER/ATTORNEY**

NUMBER OF DAYS LATE	PENALTY ASSESSMENTS AND ATTORNEY FEES
1-2	5%
3-7	10%
8-14	15%
15-30	20%
31+	25%

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 070
WORKERS' BENEFIT FUND ASSESSMENT

Effective Jan. 1, 2024

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436-070-0003 Purpose and Applicability

(1) Purpose.

These rules prescribe the rate of the Workers' Benefit Fund assessment under ORS 656.506 effective Jan. 1, 2024, the method and manner for calculating the assessment rate, and the method and manner in which employers are to pay the assessment.

(2) Applicability.

(a) These rules apply to all employers.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat Auth: ORS 656.506, 656.726(4)

Stats. Impltd: ORS 656.506

Hist: Amended 10/1/19 as WCD Admin. Order 19-055, eff. 1/1/20

Amended 10/11/21 as WCD Admin. Order 21-054, eff. 1/1/22

Amended 10/13/23 as WCD Admin. Order 23-053, eff. 1/1/24

436-070-0005 Definitions

Unless a term is defined elsewhere in these rules, the definitions of ORS chapter 656 are incorporated by reference and made a part of these rules. For the purpose of these rules, unless the context requires otherwise:

(1) **"Assessments"** means the funds due from employees and employers under ORS 656.506.

(2) **"Board"** means the Workers' Compensation Board and includes its Hearings Division.

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

(4) **"Employee"** means an Oregon subject worker as defined in ORS 656.005 and any otherwise nonsubject worker for whom coverage is elected under ORS 656.039.

(5) **"Employer"** means a subject employer as defined in ORS 656.005, including an employer that elects coverage for an otherwise nonsubject worker under ORS 656.039.

(6) **"Fund"** means the Workers' Benefit Fund as created in ORS 656.506.

(7) **"Fund balance"** means the balance of the fund after revenue and investment income has been added and expenditures have been subtracted.

Stat Auth: ORS 656.506

Stats. Impltd: ORS 656.506

Hist: Amended 3/23/05 as WCD Admin. Order 05-053, eff. 4/1/05

Amended 10/11/21 as WCD Admin. Order 21-054, eff. 1/1/22

436-070-0008 Administrative Review

(1) Request for hearing on proposed sanctions or civil penalties.

Any employer that disagrees with a proposed order, or proposed assessment of civil penalty, of the director under ORS 656.745, may request a hearing by the board. To request a hearing, the employer must:

(a) Mail or deliver a written request to the division within 60 days of the mailing date of the proposed order or assessment; and

(b) Specify, in the request, the reasons why the employer disagrees with the proposed order or assessment.

(2) Requests for hearings on other actions, including estimation actions and orders.

Any employer that disagrees with an action or order of the director under these rules, other than as described in section (1), may request a hearing by filing a request for hearing under OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Stat Auth: ORS 656.735 and 656.740

Stats. Impltd: ORS 656.704, 656.735, 656.740

Hist: Amended 10/19/05 as WCD Admin. Order 05-064, eff. 1/2/06

Amended 10/11/21 as WCD Admin. Order 21-054, eff. 1/1/22

436-070-0010 Assessment Rate: Method and Manner of Determining

(1) The assessment owed by an employer under this rule division and ORS 656.506 must be calculated using the method in OAR 436-070-0020 and based on a rate of 2.0 cents per hour.

(2) Factors considered by the director in developing the rate include, but are not limited to:

(a) The estimated annual fund expenditures and revenues;

(b) The fund balance requirements;

(c) The estimated annual hours worked per employee;

(d) The estimated number of employees covered by workers' compensation insurance; and

(e) Other records relating to fund expenditures and revenues.

Stat Auth: ORS 656.506, 656.726(4)

Stats. Impltd: ORS 656.506

Hist: Amended 10/1/19 as WCD Admin. Order 19-055, eff. 1/1/20

Amended 10/11/21 as WCD Admin. Order 21-054, eff. 1/1/22

Amended 10/13/23 as WCD Admin. Order 23-053, eff. 1/1/24

436-070-0020 Assessments: Manner and Intervals for Filing and Payment

(1) Each pay period, an employer must retain from the moneys earned by each employee an amount equal to one-half (1/2) the assessment rate under OAR 436-070-0010 multiplied by the

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number of hours or parts of an hour the employee worked in that pay period.

(a) If actual hours worked are not tracked, an employer may either calculate the assessments using a flat rate, use contract information stating the number of hours an employee works, or use another reasonable method for calculating hours worked. If the flat rate method is used, the calculation must be based on 40 hours per week for employees paid weekly or biweekly, or 173.33 hours per month for employees paid monthly or semi-monthly.

(b) If the amount to be retained from an employee under this section includes a fraction of a cent, the employer must round up or down as follows:

(A) For amounts greater than or equal to one-half (1/2) of a cent, the employer must round up to the nearest whole cent.

(B) For amounts less than one-half (1/2) of a cent, the employer must round down to the nearest whole cent.

(2) Every employer must file a report of employee hours worked and remit amounts due upon a combined tax and assessment report form prescribed by the Department of Revenue. The report must be filed with the Department of Revenue:

(a) At the times and in the manner prescribed in ORS 316.168 and 316.171; or

(b) Annually as required or allowed under ORS 316.197 or 657.571.

(3) For each period in which an employer is required to remit an assessment under section (2) of this rule, the amount of the assessment must be equal to the sum of:

(a) The total amount retained from the moneys earned by each employee during the period; and

(b) An amount equal to the amount under subsection (a) of this section, to be paid by the employer.

(4) For employers required to report quarterly, reports and payments are due on or before the last day of the first month after the close of each calendar quarter. For employers that report annually, reports and payments are due on or before the last day of January following the close of each calendar year. If the due date is on a weekend or holiday, the report and payment are due the next business day.

(5) Employers who fail to timely and accurately file and remit assessments may be charged interest on all overdue balances at the rate established by ORS 82.010 and may be assessed civil penalties in accordance with OAR 436-070-0050.

(6)(a) If an employer fails to file a report, or if the director determines, based on the available data, that the report filed understates the total assessment amount due, the director may send the employer a written Failure to File Notice or Notice of Audit Findings. The notice will include a warning that failure to timely and accurately resolve all issues addressed in the written notice may result in the imposition of a civil penalty. The director may coordinate with the Department of Revenue and Employment Department to provide written notice of failure to file.

(b) Within 30 days of the Failure to File Notice or the Notice of Audit Findings, the employer must file an accurate report and remit the assessments due, or otherwise resolve to the satisfaction of the director all issues identified in the written notice. If an employer fails to comply with the notice, the director may estimate the assessments due, including penalties and interest, and send to the employer a Notice of Estimation.

(c) Within 30 days of the Notice of Estimation, the employer must pay the director's estimated assessment or file and remit accurate assessment due. If the employer fails to comply with the notice, the director may send to the employer an Order of Default assessing all amounts due as calculated by the director.

(d) Within 30 days of the Order of Default, the employer must remit the estimated assessment due, unless the order is timely appealed as provided in OAR 436-070-0008.

(7) Employers or the director may initiate activity to resolve reporting errors, omissions, or discrepancies for a period not to exceed the current calendar year plus three prior calendar years. No calendar year limitation applies to cases involving fraud.

(8) Notwithstanding OAR 436-001-0500, when the director determines that the department has received moneys in excess of the amount legally due and payable or that it has received moneys to which it has no legal interest, the director will refund or credit the excess amount. For amounts less than \$20, the director will refund to employers the excess amount only upon receipt of a written request from the employer or the employer's legal representative.

Stat Auth: ORS 656.506 and 82.010

Stats. Impltd: ORS 656.506 and 293.445

Hist: Amended 6/15/06 as WCD Admin. Order 06-057, eff. 7/1/06

Amended 10/11/21 as WCD Admin. Order 21-054, eff. 1/1/22

436-070-0040 Monitoring/Auditing

(1) Employers must maintain payroll and employment records that reflect the total hours worked by all employees for the current calendar year plus three prior calendar years.

(2) Under ORS 656.726, the director may inspect the books, records and payrolls of employers pertinent to the administration of these rules. Employers must provide the director with all pertinent books, records and payrolls upon request.

Stat Auth: ORS 656.726

Stats. Impltd: ORS 656.506

Hist: Amended 3/23/05 as WCD Admin. Order 05-053, eff. 4/1/05

Amended 10/11/21 as WCD Admin. Order 21-054, eff. 1/1/22

436-070-0050 Assessment of Civil Penalties

The director may assess a civil penalty under ORS 656.745(2) against an employer that does not comply with ORS chapter 656, OAR 436-070, or an order of the director.

Stat Auth: ORS 656.726(4)

Stats. Impltd: ORS 656.745

Hist: Amended 12/17/19 as Admin. Order 19-065, eff. 1/1/20

Amended 10/11/21 as WCD Admin. Order 21-054, eff. 1/1/22

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 075

RETROACTIVE PROGRAM

Effective Jan. 1, 2018

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436-075-0003 Applicability of Rules

(1) These rules apply to all requests for reimbursement from the Retroactive Program involving benefits payable under:

- (a) ORS 656.204 Death;
- (b) ORS 656.206 Permanent Total Disability;
- (c) ORS 656.208 Death During Permanent Total Disability; and
- (d) ORS 656.210 Temporary Total Disability for injuries before April 1, 1974.

(2) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Statutory authority: ORS 656.506, 656.726(4)
Statutes implemented: ORS 656.204[OL 2017, ch. 71], 656.206 [OL 2017, ch. 70], 656.208, 656.209, 656.210, 656.236, 656.289, 656.506
Hist: Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18

436-075-0005 Definitions

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made a part of these rules. For the purposes of these rules, unless the context requires otherwise:

- (1) "**Child**" is as defined in ORS chapter 656 applicable at the worker's date of injury.
- (2) "**Department**" means the Department of Consumer and Business Services.
- (3) "**Director**" means the director of the Department of Consumer and Business Services or the director's designee.
- (4) "**Insurer**" means the State Accident Insurance Fund Corporation, an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state, or an

employer or employer group that has been certified as self-insured under ORS 656.430.

(5) "**Mailed**" or "**mailing date**," unless otherwise specified, means:

- (a) The date a document is postmarked;
- (b) The date automatically produced by electronic transmission (e.g., email or facsimile);
- (c) The date a hand-delivered document is stamped or punched in by the recipient; or
- (d) The date of a phone, or in-person request, when allowed under these rules.

(6) "**Retroactive Program benefit**" means the additional amount paid to an eligible worker or beneficiary when benefit levels are lower than what is currently paid for like injuries.

(7) "**Spouse**" includes cohabitants under ORS 656.226.

(8) "**Statutory benefit**" means any benefit payable to or on behalf of the injured worker under the law in effect at the time of the worker's injury, as modified by marital and dependency status changes.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.005, 656.726(4)
Hist: Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18

436-075-0008 Administrative Review

(1) Any party aggrieved by a proposed order or proposed assessment of civil penalty issued under ORS 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board under ORS 656.740. To request a hearing the party, or assigned claims agent, must:

- (a) Mail or deliver a written request for hearing to the Workers' Compensation Division within 60 days of the mailing date of the proposed order or assessment; and
- (b) Specify the reasons why the party or assigned claims agent disagrees with the proposed order or assessment in the request.

(2) Any party that disagrees with an action or order of the director under these rules, other than as described in section (1) of this rule, may request a hearing by filing a request for hearing under OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.704, 656.740, 656.745
Hist: Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18
SMC (repeal of ORS 656.750)– ORS 183.335(7), filed and effective 6/18/24

436-075-0010 Criteria for Eligibility

(1) The department will issue a bulletin to notify all insurers of changes in the Retroactive Program benefit levels whenever the director determines a change is necessary under ORS 656.506(7).

(2) Eligibility for Retroactive Program benefits is based on the worker's injury date as follows:

- (a) Workers or beneficiaries eligible to receive either death or permanent total disability benefits become eligible for Retroactive Program benefit increases when the benefits granted under the Retroactive Program bulletin exceed the

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benefits provided by the statute in effect at the time of the injury.

(b) Workers receiving temporary total disability benefits are eligible for Retroactive Program benefit increases as follows:

(A) Workers with injuries occurring before July 1, 1973 are eligible for Retroactive Program benefit increases;

(B) Workers with injuries occurring from July 1, 1973 through April 1, 1974 may be eligible for benefits according to the limits defined in the Retroactive Program bulletin; and

(C) Workers with injuries occurring on or after April 1, 1974 are not eligible to receive Retroactive Program increases to their temporary total disability benefit.

(3) A claim is not eligible for Retroactive Program benefits if all issues except compensable medical services are disposed of under ORS 656.236 or settled under ORS 656.289 before becoming eligible under section (2) of this rule.

(4) Costs for claims of subject workers of a noncomplying employer under ORS 656.052 are not eligible for reimbursement from the program, but remain a cost recoverable from the employer under ORS 656.054(2).

Statutory authority: ORS 656.506, 656.726(4)
Statutes implemented: ORS 656.236, 656.289, 656.506
Hist: Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18

436-075-0020 Death Benefit

(1) Death benefits must be paid to eligible beneficiaries under ORS 656.204, OAR 436-060-0075, and the benefit schedules in the Retroactive Program bulletin.

(2) The statutory death benefit for injuries occurring from July 1, 1973 through April 1, 1974 will be reduced by the Social Security benefits received by the worker's surviving spouse, not to exceed the July 1, 1973 statutory benefit level. The amount of reduction to the statutory benefit is a Retroactive Program benefit. The insurer may request reimbursement only for the adjusted Retroactive Program benefit.

(3) At least once every two years, the insurer must verify that all beneficiaries receiving death benefits for which the insurer may request reimbursement from the Retroactive Program are alive and remain eligible for those benefits. Insurers' questions regarding beneficiaries' status must be reasonably pertinent to the continuing eligibility of those persons for benefits.

Statutory authority: ORS 656.506, 656.726(4)
Statutes implemented: ORS 656.204 [OL 2017, ch. 71], 656.506
Hist: Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18

436-075-0030 Permanent Total Disability Benefit

(1) Permanent total disability benefits must be paid under ORS 656.206 and the benefit schedules in the Retroactive Program bulletin.

(2) Benefits payable for a partial month must be calculated by dividing the monthly benefit by the actual number of days in the month and multiplying that result by the number of days payable.

(3) Benefits for beneficiaries must be paid to the date of any status change.

(4) Any Social Security offset determined under ORS 656.209 must first be applied against the statutory portion of the permanent total disability benefit. Any amount of the Social Security offset that exceeds the statutory benefit must be applied against the Retroactive Program benefit. The insurer may request reimbursement only for that portion of the Retroactive Program benefit that has not been offset.

(5) At least once every two years, the insurer must verify that all beneficiaries receiving benefits for which the insurer may request reimbursement from the Retroactive Program are alive and remain eligible for those benefits. Such "status checks" of beneficiaries may occur at the same time the insurer re-examines the permanent total disability claim under OAR 436-030-0065(1). Insurers' questions regarding beneficiaries' status must be reasonably pertinent to the continuing eligibility of those persons for benefits.

Statutory authority: ORS 656.506, 656.726(4)
Statutes implemented: ORS 656.206 [OL 2017, ch. 70], 656.209, 656.506
Hist: Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18

436-075-0040 Death during Permanent Total Disability

(1) If the injured worker dies during the period of permanent total disability, death benefits must be paid to eligible beneficiaries under ORS 656.208, 656.204, OAR 436-060-0075, and the benefit schedules in the Retroactive Program bulletin.

(2) The statutory death benefit for injuries occurring from July 1, 1973 to April 1, 1974 will be reduced by the Social Security benefits received by the worker or the worker's surviving spouse, not to exceed the July 1, 1973 statutory benefit level. The amount of reduction to the statutory benefit is a Retroactive Program benefit. The insurer may request reimbursement only for the adjusted Retroactive Program benefit.

(3) At least once every two years, the insurer must verify that all beneficiaries receiving death benefits for which the insurer may request reimbursement from the Retroactive Program are alive and remain eligible for those benefits. Insurers' questions regarding beneficiaries' status must be reasonably pertinent to the continuing eligibility of those persons for benefits.

Statutory authority: ORS 656.506, 656.726(4)
Statutes implemented: ORS 656.204 [OL 2017, ch. 71], 656.208, 656.506
Hist: Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18

436-075-0050 Temporary Total Disability

(1) Temporary total disability benefits must be paid under ORS 656.210, OAR 436-060-0150, and the benefit schedules in the Retroactive Program bulletin.

(2) The computation of benefits under these rules and the Retroactive Program bulletin may not reduce temporary total disability benefits currently being paid.

Stat. authority: ORS 656.506
Stats implemented: ORS 656.210
Hist: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16

436-075-0065 Dispositions

(1) Any disposition of the claim by the parties under ORS 656.236, or settlement of the claim under ORS 656.289, is not eligible for reimbursement from the Retroactive Program unless

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it is approved by the director before it is submitted to the Workers' Compensation Board.

(2) Requests for the director's approval of proposed dispositions must be made in writing, and must include:

(a) A copy of the proposed disposition that specifies the amount of the proposed contribution to be made from the Retroactive Program;

(b) A statement from the insurer indicating how the amount of the contribution was calculated; and

(c) Any other information required by the director.

(3) The director will not approve the disposition if:

(a) The ratio of the amount requested from the program to the total amount of the disposition exceeds the percentage of current benefits due the worker from the program; or

(b) The settlement exceeds a reasonable projection of future liability.

(4) The insurer must submit dispositions to the Workers' Compensation Division in the format prescribed by the director.

Stat. authority: ORS 656.506, 656.726(4)

Stats implemented: ORS 656.236, 656.289

Hist: Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18

436-075-0070 Reimbursement

(1) Reimbursement from the Retroactive Program will be authorized by the Workers' Compensation Division on a quarterly basis.

(2) Requests for reimbursement must be mailed or delivered to the Workers' Compensation Division within 30 days after the end of each calendar quarter to be processed in that quarterly disbursement.

(3) Requests for reimbursement mailed or delivered to the Workers' Compensation Division more than 30 days after the end of the quarter will be processed with the next quarterly disbursement.

(4) A separate request for reimbursement must be submitted for each insurer and include a signed certification that the payments reported on the request have been made in the amounts reported.

(5) The insurer must use [Form 3285](#), "Request for Reimbursement from the Retroactive Program," or an equivalent form, to request reimbursement from the Retroactive Program.

(a) If an equivalent form is used, it must include all of the data elements on Form 3285; and

(b) Each request must accurately reflect the marital and dependency status in effect and eligible for reimbursement in the period requested.

(6) The director will not process any request that does not meet the requirements of section (4) and (5) of this rule.

(7) The department will recover any overpayment made to an insurer as a result of an insurer reporting error or incorrect information submitted on a quarterly request form.

(8) If a denied claim is found to be compensable by an administrative law judge, the Workers' Compensation Board, or

the Court of Appeals, and that decision is subsequently reversed by a higher level of appeal, the insurer will receive reimbursement for Retroactive Program benefit payments required to be made while the claim was in an accepted status.

Stat. authority: ORS 656.506, 656.726(4)

Stats implemented: ORS 656.506

Hist: Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18

436-075-0090 Third Party Recovery

(1) In a third party recovery, previously reimbursed Retroactive Program benefits are a portion of the paying agency's lien.

(2) When the insurer learns of third-party settlement negotiations on any claim for which it has received reimbursement from the Retroactive Program, the insurer must notify the Workers' Compensation Division.

(3) The insurer must make remittance on recovered Retroactive Program benefits to the department in the quarter following the recovery in amounts determined under ORS 656.591 and 656.593.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.506, 656.591, 656.593

Hist: Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18

436-075-0100 Assessment of Civil Penalties

Under ORS 656.745 the director may assess a civil penalty against an insurer for failure to comply with these rules. Penalty orders will be issued under ORS 656.447 and 656.704 and are subject to review under OAR 436-075-0008.

Statutory authority: ORS 656.745

Statutes implemented: ORS 656.204, 656.726, 656.745 and 656.447

Hist: Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 080
NONCOMPLYING EMPLOYERS

Effective June 19, 2020

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436-080-0003 Applicability and Purpose of Rules

(1) Purpose.

These rules carry out the provisions of ORS 656.017, 656.052, 656.054, 656.407, 656.735, and 656.740.

(2) Applicability.

These rules apply to all orders issued under ORS 656.052, 656.735, or 656.740 on or after the effective date of these rules.

(3) Director's discretion.

The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.017; 656.052; 656.054; 656.735 and 656.740.

Hist: Amended 11/14/18 as WCD Admin. Order 18-062, eff. 1/1/19

436-080-0005 Definitions

Unless a term is defined in these rules or the context otherwise requires, the definitions of ORS chapter 656 are incorporated by reference and made part of these rules. For the purpose of these rules, unless the context requires otherwise:

(1) "Board" means the Workers' Compensation Board and includes its Hearings Division.

(2) "Director" means the director of the Department of Consumer and Business Services or the director's designee.

(3) "Noncomplying employer order" means an order issued under these rules declaring an employer to be a noncomplying employer and containing the amount of civil penalty assessed under ORS 656.735, if any.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.726

Hist: Amended 11/14/18 as WCD Admin. Order 18-062, eff. 1/1/19

436-080-0010 Issuance of Noncomplying Employer Order; Requests for Hearing

(1) Issuance of noncomplying employer order.

If the director determines that a person has engaged as a subject employer without qualifying as a carrier-insured employer or a self-insured employer as provided in ORS 656.017 and 656.407, the director will issue a noncomplying employer order.

(2) Request for hearing.

An employer may contest a noncomplying employer order by requesting a hearing under ORS 656.740, subject to the following:

(a) The request for hearing must be made in writing;

(b) The request must specify the grounds upon which the employer contests the order;

(c) The request must be filed with the director within 60 calendar days after the mailing date of the order; and

(d) OAR 436-001-0030(2) through (5) apply to hearings requested under this section.

(3) Proceedings to enjoin a noncomplying employer.

The director may request the Department of Justice to commence proceedings to enjoin a noncomplying employer that does not request a hearing within the timeframe specified under subsection (2)(c) of this rule from employing subject workers without complying with ORS 656.017.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.017, 656.052, 656.407, 656.735, ORS 656.740

Hist: Amended 11/14/18 as WCD Admin. Order 18-062, eff. 1/1/19

436-080-0040 Assessment of Civil Penalties Against Non-complying Employer

(1) Calculation of premium amounts.

For the purpose of this rule, "premium for the period of noncompliance" means the estimated premium the employer would have paid during the period of noncompliance if workers' compensation insurance had been provided. The director will estimate the premium for the period of noncompliance, subject to the following:

(a) The director will use the applicable assigned risk rates established by the National Council on Compensation Insurance effective during the period of noncompliance. The rates are available for purchase at www.ncci.com, or are available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301;

(b) If the employer provides payroll information that is adequate to determine actual payroll amounts and duties performed by workers, the director will assign the payroll amounts to the applicable assigned risk rates; and

(c) If the employer does not provide payroll information that is adequate to determine actual payroll amounts and duties performed by workers:

(A) The director may estimate payroll by multiplying the total number of workers employed during the period of noncompliance by the state average weekly wage; and

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(B) The director may assign all estimated payroll to the classification that best describes the employer's type of business.

(2) Assessment of civil penalties under ORS 656.735(1).

The director will assess a civil penalty under ORS 656.735(1) for a person's first violation of ORS 656.052(1) in an amount equal to the greater of:

- (a) \$1,000; or
- (b) 200 percent of premium for the period of noncompliance.

(3) Assessment of civil penalties under ORS 656.735(2).

If an employer continues to violate ORS 656.052(1) after an order under OAR 436-080-0010 has become final, the director will assess an additional civil penalty of not more than \$250 for each calendar day the violation continues, commencing with the first day of noncompliance after the initial noncomplying period. To determine the amount of a civil penalty assessed under this section, the director may consider factors including, but not limited to:

- (a) The number of subject workers employed by the noncomplying employer;
- (b) The nature of the noncomplying employer's business;
- (c) The premium for the period of noncompliance; and
- (d) The employer's compliance history.

(4) Penalty reductions.

The director may reduce the amount of a civil penalty assessed under section (2) or (3) of this rule, subject to the following:

- (a) To be eligible for a reduced penalty, the employer must:
 - (A) Agree to not contest the penalty order;
 - (B) Provide evidence that the employer has complied with ORS 656.017, or that it is no longer a subject employer;
 - (C) Provide adequate payroll information to enable the director to calculate premium for the period of noncompliance under subsection (1)(b) of this rule; and
 - (D) Make arrangements for prompt payment of the reduced penalty amount;
 - (b) The director will not reduce a civil penalty if the employer fails to comply with subsection (a) before the order assessing the penalty becomes final, unless the director determines there was good cause for the delay;
 - (c) A penalty assessed under section (2) of this rule may be reduced to the greater of:
 - (A) \$500; or
 - (B) 105 percent of premium for the period of noncompliance; and
 - (d) A penalty assessed under section (3) of this rule may be reduced to the greater of:
 - (A) \$1,000; or
 - (B) 150 percent of premium for the period of noncompliance.
- If 150 percent of premium for the period of noncompliance is equal to or greater than \$250 per calendar day of

noncompliance, there will be no reduction of the penalty amount.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.735

Hist.: Amended 11/14/18 as WCD Admin. Order 18-062, eff. 1/1/19

Amended 5/28/20 as WCD Admin. Order 20-057, eff. 6/1/20 (temporary)

Suspended eff. 6/18/20 as WCD Admin. Order 20-058, eff. 6/18/20 (temporary)

Reinstated 6/18/20 as WCD Admin. Order 18-062, eff. 6/19/20

436-080-0060 When a Worker Files a Claim for an Injury

(1) Referral of claim to assigned claims agent.

If a worker files a claim for an injury sustained while the worker was employed by a noncomplying employer, the director will:

(a) Refer the claim, with a copy of the noncomplying employer order and the results of the compliance investigation, to the assigned claims agent for processing; and

(b) Issue a Notice of Referral to the worker, the worker's representative, if represented, and the employer. The notice will inform the employer of its right to object to the claim.

(2) Request for hearing to object to a claim.

An employer may request a hearing to object to a claim referred to the assigned claims agent under this rule. The request for hearing must be filed with the board within 60 calendar days after the mailing date of the Notice of Referral issued under subsection (1)(b) of this rule.

(3) Processing of claim.

When the assigned claims agent accepts or denies the claim, it must notify the worker, employer, and the director within the time provided by ORS 656.262.

(4) Nonsubjectivity determinations.

If a worker files a claim for an injury and the director determines that the worker was not a subject worker, or the employer was not a subject employer, the director will notify the worker and the employer by issuing a nonsubjectivity determination.

(5) Request for hearing on nonsubjectivity determination.

A worker may request a hearing on a nonsubjectivity determination, subject to the following:

- (a) The request for hearing must be filed within 60 days after the mailing date of the determination;
- (b) The request for hearing must be sent to the director;
- (c) The worker and employer are parties to the hearing; and
- (d) OAR 436-001-0030(2) through (5) apply to hearings requested under this section.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.054; 656.740

Hist.: Amended 11/14/18 as WCD Admin. Order 18-062, eff. 1/1/19

436-080-0065 Determination of Assigned Claims Agent

(1) When selecting an assigned claims agent, the director will consider:

- (a) Which claims agent can deliver the most timely and appropriate benefits to injured workers and can best control

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claim costs and administrative costs, based on claims processing performance and other available data; and

(b) Any other factors the director considers appropriate.

(2) If no qualified entity agrees to be an assigned claims agent, the director may require one or more of the three highest premium producing insurers to be assigned claims agents, based on the criteria under section (1) of this rule.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.054

Hist: Amended 11/14/18 as WCD Admin. Order 18-062, eff. 1/1/19

436-080-0070 Reimbursement of Assigned Claims Agent for Claims Costs for Injured Workers of Noncomplying Employers

(1) Reimbursement of incurred claims costs.

The director will reimburse the assigned claims agent for all claims costs the assigned claims agent incurs under ORS 656.054, under the terms of the contract between the assigned claims agent and the director. To request reimbursement, the assigned claims agent must report all claims costs to the director, subject to the following:

(a) Claims costs for which reimbursement will be allowed include, but are not limited to:

(A) All compensation provided to a subject worker or beneficiary;

(B) Attorney fees and sums assessed under ORS 656.382(3), but not fees and sums paid under ORS 656.262(11) and 656.382(1); and

(C) A reasonable amount for administrative costs at a rate proposed by the assigned claims agent and approved by the director. The assigned claims agent must propose the rate before June 30 of each year. Late proposals for a rate increase, if approved, will be effective on the date the request was received by the director;

(b) If the assigned claims agent is the paying agency in any action to recover damages from a noncomplying employer or third party under ORS 656.576 to 656.595, the assigned claims agent must report to the director:

(A) The commencement and termination of each action;

(B) The status of all pending actions at the end of each calendar year; and

(C) The amount of the recovery retained by the assigned claims agent under ORS 656.593(1)(c), within 30 days after an action is settled or damages are recovered; and

(c) The amount reported under paragraph (1)(b)(C) will be offset against the amount of incurred costs reported under subsection (a).

(2) Approval or denial of request.

The director will review the request and will approve or disapprove the reimbursement from the Workers' Benefit Fund under the terms of the contract between the assigned claims agent and the director.

(3) Audit of reimbursed amounts.

The director will annually audit the noncomplying employer claim files processed by the assigned claims agent to validate the amount reimbursed under section (2) of this rule. The director will disapprove reimbursement if any of the conditions described under ORS 656.054(3) are found to apply upon audit.

(4) Review of disapproval.

The assigned claims agent may request review of any disapproval of reimbursement made by the director under ORS 656.704(2) and OAR 436-001.

(5) Collection of reimbursed costs.

The director will collect all costs reimbursed from the Workers' Benefit Fund under this rule from the responsible noncomplying employer. The director will inform each noncomplying employer of its liability and advise the employer of costs incurred by the assigned claims agent.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.054, 656.704

Hist: Amended 11/14/18 as WCD Admin. Order 18-062, eff. 1/1/19

436-080-0080 Collection of Monies Withheld from Subject Workers

The director will collect any unremitted monies withheld by a noncomplying employer from subject workers under ORS 656.506, as described under OAR 436-070.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.506

Hist.: Amended 12/3/03 as WCD Admin Order 03-065, eff. 1/1/04

Amended 11/14/18 as WCD Admin. Order 18-062, eff. 1/1/19

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 085

PREMIUM ASSESSMENT

Effective Jan. 1, 2020

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436-085-0003 Purpose and Applicability

(1) These rules carry out the workers' compensation law related to the development and collection of assessments from insurers, self-insured employers, and self-insured employer groups.

(2) These rules apply to assessments paid by insurers, self-insured employers, and self-insured employer groups under ORS 656.612 and 656.614.

(3) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: 656.612, 656.614, 656.726(4)
Stats. Implemented: ORS 656.612, 656.614
Hist: Amended 12/17/19 as Admin. Order 19-058, eff. 1/1/20

436-085-0005 Definitions

Unless a term is defined elsewhere in these rules, the definitions of ORS chapter 656 are incorporated by reference and made a part of these rules. For the purpose of these rules, unless the context requires otherwise:

(1) **"Assessable earned premium"** means the amount of earned premium that is subject to premium assessment.

(2) **"Board"** means the Workers' Compensation Board and includes its Hearings Division.

(3) **"Director"** means the director of the Department of Consumer and Business Services or the director's designee.

(4) **"Earned premium"** means the total amount of workers' compensation insurance premium earned by an insurer before any modification for premium assessment purposes.

(5) **"Exempted earned premium"** means premium earned on:

(a) Insurance under the jurisdiction of the federal government, including the Longshore and Harbor Workers' Compensation Act, Federal Employers Liability Act, and Jones Act; and

(b) Employer liability increased limits premium that would be reported on Statutory Page 14 (Business in the State of Oregon), column 2, line 16 of the insurer's annual statement under OAR 836-011-0000.

(6) **"Insurer"** means the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in this state.

(7) **"Premium assessments"** means moneys due the director under ORS 656.612 and 656.614.

(8) **"Self-Insured employer"** means an employer that has been certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407.

(9) **"Self-Insured employer group"** means five or more employers certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407 and OAR 436-050-0260 through 436-050-0340.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.726
Hist: Amended 12/17/19 as Admin. Order 19-058, eff. 1/1/20

436-085-0008 Administrative Review

(1) Any party that disagrees with a proposed order or proposed assessment of civil penalty issued by the director under these rules may request a hearing by the board under ORS 656.740. To request a hearing, the party must:

(a) Mail or deliver a written request to the Workers' Compensation Division within 60 days of the mailing date of the proposed order or assessment; and

(b) Specify, in the request, the reasons why the party disagrees with the proposed order or assessment.

(2) Any party that disagrees with an action taken under these rules, other than as described in section (1) of this rule, may request a hearing as provided under OAR 436-001-0019 by filing a request within 30 days of the mailing date of the notice of action. OAR 436-001 applies to the hearing.

Stat. Auth.: 656.612, 656.614 & 656.726(4), 656.740
Stats. Implemented: ORS 656.704, OL 2005 ch 26, 656.735, 656.740, 656.745
Hist: Amended 12/17/19 as Admin. Order 19-058, eff. 1/1/20

436-085-0015 Premium Assessment; Determination of Assessable Premium: Insurers

(1) For the purpose of these rules, "direct earned premium," as used in ORS 656.612 means "assessable earned premium."

(2) Assessable earned premium must be calculated by making the following modifications to earned premium:

(a) Subtracting exempted earned premium. The amount of exempted earned premium subtracted must be determined on a direct basis prior to reinsurance transactions; and

(b) Adding large deductible premium credits or modifications.

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(3) Earned premium must be calculated in the same manner as direct premiums earned, as reported on Statutory Page 14 (Business in the State of Oregon), column 2, line 16 of the insurer's annual statement under OAR 836-011-0000. Earned premium:

(a) Excludes reinsurance accepted and is without deduction of reinsurance ceded;

(b) Excludes large deductible credits or modifications;

(c) Includes experience rating, premium discounts, retrospective rating, audit premiums, foreign terrorism premiums, domestic terrorism and catastrophic premiums, and other individual risk rating adjustments; and

(d) Excludes deposit premiums.

Stat. Auth.: 656.612, 656.726(4)

Stats. Implemented: ORS 656.612

Hist: Adopted 12/17/19 as Admin. Order 19-058, eff. 1/1/20

436-085-0025 Premium Assessment; Manner and Intervals for Reporting and Payments: Insurers

(1) Insurers must report and pay premium assessments using a completed [Form 910](#), "Workers' Compensation Insurer Premium Assessment Report." The report must be signed by the person who prepares the report.

(2) An insurer must report and pay premium assessment based on the insurer's assessable earned premium and the premium assessment rate in effect under OAR 440-045 no later than:

(a) November 15, for the quarter ending September 30;

(b) February 15, for the quarter ending December 31;

(c) May 15, for the quarter ending March 31; and

(d) August 15, for the quarter ending June 30.

(3) The director may allow an insurer to report and pay premium assessments annually when the insurer's annual premium assessment has been less than \$1,000 for at least two consecutive years.

(a) An eligible insurer under this section may choose to:

(A) Continue reporting and paying quarterly; or

(B) Revert to reporting and paying quarterly after having reported and paid annually for at least one year.

(b) The insurer must notify the director of its choice in writing before the first quarter's premium assessment due date. An insurer's reporting and payment frequency remains in effect for the full calendar year and cannot be changed mid-year.

(4) The director may waive an insurer's reporting requirement after confirming that the insurer has had no earned premium for at least four consecutive quarters. A waiver remains in effect until premium is earned.

(5) Assessable earned premium reported by insurers is final except for corrections made as a result of audits by the director, examinations by the Division of Financial Regulation or insurance regulator of the insurer's state of domicile, or detection of a clerical error by the insurer. All such corrections will be made at the premium assessment rate in effect for the year being corrected.

(6) Each insurer, including each insurer operating within an insurer group, must report and pay premium assessment using a separate [Form 910](#) and check.

(7) The insurer must maintain sufficient documentation for the director to verify the amount of assessable earned premium reported to the director and any adjustments or corrections.

Stat. Auth.: 656.612, 656.614, 656.726(4)

Stats. Implemented: ORS 656.612, 656.614

Hist: Amended 12/17/19 as Admin. Order 19-058, eff. 1/1/20

436-085-0030 Premium Assessment; Manner and Intervals for Payments; Experience Rating Modification Factors: Self-Insured Employers and Self-Insured Employer Groups

(1) As used in this rule, the term "self-insured employers" includes self-insured employer groups.

(2) Self-insured employers must report and pay premium assessments using a completed [Form 900](#), "Payroll and Assessment Quarterly Report - Retrospective rating plan," or [Form 937](#), "Payroll and Assessment Quarterly Report - Normal plan." The report must be certified to be true and accurate by an authorized representative of the self-insured employer.

(3) For premium assessment purposes, the premium of all self-insured employers will be calculated using rates developed by the director. The rates for each fiscal year will be developed by applying a multiplier determined by the director to the manual rates published by the National Council on Compensation Insurance effective and published by April 1 of the previous fiscal year.

(a) The multiplier will be no greater than the average of all loss cost multipliers filed with the Division of Financial Regulation effective and filed by April 1 of the previous fiscal year, weighted by market share.

(b) For the purpose of determining the multiplier, the director may consider factors including, but not limited to, the net difference between the maximum multiplier possible under subsection (a) of this section and the modifier used in the preceding fiscal year.

(4) Self-insured employers may choose to have their premium calculated using either:

(a) The normal method of calculation, which is manual premium modified by experience rating and premium discount; or

(b) A one-year retrospective rating plan developed by the Division of Financial Regulation and approved by the director. However, any employer becoming self-insured after July 1 may not choose a retrospective rating plan for that fiscal year.

(5) On or before May 31 of each year, the director will issue a bulletin notifying all self-insured employers of the premium rates and retrospective rating plans to be used in the fiscal year beginning July 1.

(6) On or before July 1 of each year, a self-insured employer may change its current method of premium calculation by submitting written notification of its choice to the director. Once chosen, the method may not be changed for that fiscal

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year and remains in effect until the self-insured employer chooses to change the method.

(7) A self-insured employer must use the normal method of premium calculation unless it has notified the director that it chooses to use a one-year retrospective rating plan.

(8) A self-insured employer must report and pay premium assessment based on the self-insured employer's premium and the premium assessment rate in effect under OAR 440-045 no later than:

- (a) October 31, for the quarter ending September 30;
- (b) January 31, for the quarter ending December 31;
- (c) April 30, for the quarter ending March 31; and
- (d) July 31, for the quarter ending June 30.

(9) Premium assessment for a self-insured employer that has chosen to have its premium calculated using a retrospective rating plan must be based on 80 percent of the self-insured employer's assessable premium until adjusted by retrospective rating.

(10) All premium adjustments resulting from retrospective rating plans or payroll audits must be made using the premium assessment rate or rates in effect for the period being adjusted.

(11) When retrospective rating adjustments are made to periods where more than one assessment rate applied, the adjusted premium will be prorated in direct proportion to the self-insured employer's assessable premium for each period. Total premium assessment due for the entire period will be adjusted on the same basis.

(12) The director will determine an experience rating modification factor for each self-insured employer.

(a) The director will calculate experience rating modification factors using the method provided by the National Council on Compensation Insurance in the *Experience Rating Plan Manual - 2003 Edition*, except that the director will use only Oregon claims and payroll exposure, and will assign a policy period of July 1 through the following June 30. A copy of the *Experience Rating Plan Manual - 2003 Edition* is available for review during regular business hours at the Workers' Compensation Division, 350 Winter St. NE, Salem OR 97301.

(b) The self-insured employer's authorized claims processing location(s) must provide the director with the loss information necessary to calculate the experience rating modification factor.

(c) If sufficient Oregon experience is not available to calculate an experience rating modification factor based on Oregon experience only, the director will assign the self-insured employer an experience rating modification factor of 1.00.

(d) If payroll information submitted by a self-insured employer is determined to be incorrect, the director may order, or the self-insured employer may request, a revision of experience rating modification factors using that data. Only payroll information reported in the last three calendar years may be corrected. The director will recalculate all experience rating modification factors previously calculated using the incorrect payroll information.

(e) When the director orders an adjustment to the experience rating modification factor for a particular policy period, the adjustment will be applied retroactively to the beginning of the period. Any resulting increase in the assessment is payable on demand. Any resulting decrease may be applied against the next quarterly assessment payment.

(13) The director may waive a self-insured employer's reporting requirement on the self-insured employer's request after confirming that the self-insured employer has had no Oregon payroll for four consecutive quarters. The waiver will remain in effect until the self-insured employer has Oregon payroll.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.612, 656.614

Hist: Amended 12/17/19 as Admin. Order 19-058, eff. 1/1/20

436-085-0035 Audits

The director will monitor and conduct periodic audits of insurers, self-insured employers, and self-insured employer groups to ensure compliance with these rules.

Stat. Auth.: ORS 656.726

Stats. Implemented: 656.726, 656.745

Hist: Amended 12/17/19 as Admin. Order 19-058, eff. 1/1/20

436-085-0060 Assessment of Civil Penalties

The director may assess a civil penalty under ORS 656.745(2) against an insurer, self-insured employer, or self-insured employer group that violates ORS chapter 656, OAR 436-085, or an order of the director.

Stat. Auth.: 656.612, 656.614, 656.726(4)

Stats. Implemented: ORS 656.735, 656.740, 656.745

Hist: Amended 12/17/19 as Admin. Order 19-066, eff. 1/1/20

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 100

WORKERS' COMPENSATION BENEFITS OFFSET

Effective Jan. 1, 2016

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436-100-0001 Authority for Rules

(1) These rules are promulgated under the director's authority contained in ORS 656.726 and 656.727.

Stat. Auth.: ORS 656.209, ORS 656.726 and ORS 656.727
Stats. Implemented: ORS 656.209
Hist.: WCD 2-1984 (Admin), filed & eff. 2/22/84

436-100-0002 Purpose

The purpose of these rules is to establish requirements and procedures for offsetting permanent total disability benefits against social security disability benefits.

Stat. Auth.: ORS 656.209 and ORS 656.727
Stats. Implemented: ORS 656.209
Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16

436-100-0003 Applicability of Rules

(1) These rules are effective January 1, 2016, to carry out the provisions of ORS 656.209 and 656.727.

(2) These rules apply to:

(a) Those workers receiving awards for permanent total disability and eligible for and receiving federal social security disability benefits; and

(b) Injured workers whose period of disability under the Social Security Administration began on or after June 1, 1965.

(3) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.209 and ORS 656.727
Stats. Implemented: ORS 656.209
Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16

436-100-0005 Definitions

(1) "Authorization" means an order issued by the Workers' Compensation Division directing the paying agent to offset the worker's permanent total disability benefits by the amount specified in the order.

(2) "Beneficiary" means an injured worker, and the spouse, child or dependent of a worker, who is entitled to receive payments under ORS 656.001 through 656.794.

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

(4) "Director" means the director of the Department of Consumer and Business Services or the director's designee.

(5) "Division" means the Workers' Compensation Division.

(6) "Federal Disability Benefit Limitation" means the amount determined under 42 USC 224(a) and Social Security Administration rules.

(7) "Offset" means a reduction of permanent total disability benefits based on the amount of federal social security disability benefits received by a worker.

(8) "Paying agency" or "paying agent" means the self-insured employer or insurer paying benefits to the worker or beneficiaries.

(9) "Performance Section" means the Performance Section of the Workers' Compensation Division.

(10) "Permanent total disability benefits" means compensation to an injured worker awarded permanent total disability compensation under ORS 656.206.

(11) "Worker" means any worker receiving permanent total disability benefits.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.209
Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16

436-100-0006 Administration of Rules

In administration of these rules, orders of the Workers' Compensation Division are deemed orders of the director.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.209 and ORS 656.726
Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16

436-100-0008 Administrative Review

(1) Any worker aggrieved by any offset authorization of the division may apply to the Workers' Compensation Division for a reconsideration of that authorization before requesting a hearing.

(2) Any party aggrieved may request a hearing under ORS 656.283.

Stat. Auth.: ORS 656.726 and ORS 656.727
Stats. Implemented: ORS 656.209
Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16

436-100-0010 Criteria for Eligibility

(1) Permanent total disability benefits must be offset by the workers' social security disability benefits. However, the total combined benefit, permanent total disability benefits plus social security disability benefits, must not be offset to an amount less than the greater of:

(a) The amount the worker would have received under ORS chapter 656; or

(b) The Federal Disability Benefit Limitation.

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(2) Permanent total disability benefits must not be paid by the paying agent in an amount greater than authorized by ORS Chapter 656.

(3) Offset of permanent total disability benefits must be made by a paying agent only in an amount and as authorized by the director.

(4) Offset of permanent total disability benefits will be authorized by the director only upon actual receipt of federal social security disability benefits by the injured worker.

Stat. Auth.: ORS 656.209 and ORS 656.727

Stats. Implemented: ORS 656.209

Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16

436-100-0020 Requirements of Workers

(1) Workers entitled to receive permanent total disability benefits must make application for federal social security disability benefits.

(2) Workers and eligible beneficiaries must, upon department request, execute a release form authorizing the Social Security Administration to make disclosure to the department of such information regarding the injured workers as will enable the department to carry out the provisions of ORS 656.209 and these rules.

(3) Whenever there is a change in the federal social security beneficiary eligibility, the worker must notify the Performance Section.

(4) Upon request of the department, the worker may be required at any time to furnish additional information regarding social security disability benefits.

Stat. Auth.: ORS 656.209 and ORS 656.727

Stats. Implemented: ORS 656.209 and ORS 656.727

Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16

436-100-0030 Authorization of Offset; Effective Date

(1) Authorization issued by the department will be directed to the paying agent with a copy to the injured worker.

(2) A paying agent making payment of permanent total disability benefits will be entitled to social security disability offset only as authorized by the department.

(3) The department will review the social security offset calculation when notified of a change in the status of a worker subject to social security offset. An amended authorization will be issued, if necessary.

(4) Whenever there is a change in eligibility status of the worker or any one of the worker's beneficiaries receiving benefits for permanent total disability subject to offset, the paying agent must notify the Performance Section.

(5) The paying agent must, immediately upon the death of a worker, terminate payment of previously authorized permanent total disability benefits offset and begin payment of other compensation due under ORS chapter 656, if any.

(6) The effective date of offset must be the effective date established in the authorization.

Stat. Auth.: ORS 656.209 and ORS 656.727

Stats. Implemented: ORS 656.209 and ORS 656.727

Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16

436-100-0040 Sanctions Against Worker for Failure to Cooperate With the Department

(1) Any worker entitled to receive permanent total disability benefits who fails to comply with these rules will be subject to suspension of benefits until the worker has complied.

(2) If a worker fails to comply with these rules, the director will make a written demand upon the worker by personal service or registered mail. If the worker fails to comply within 20 days of receipt of the demand, the director may authorize suspension of benefits until the worker complies.

(3) An order of suspension of benefits will continue in force from the date issued until the date the worker actually complies with these rules.

(4) No compensation will become due or be payable during a period of suspension of benefits.

Stat. Auth.: ORS 656.209 and ORS 656.727

Stats. Implemented: ORS 656.209 and ORS 656.727

Hist.: Amended 10/12/15 as WCD Admin. Order 15-064, eff. 1/1/16

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 105
EMPLOYER-AT-INJURY PROGRAM

Effective July. 1, 2022

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436-105-0003 Purpose and Applicability

(1) Purpose.

(a) The rules in OAR 436-105 explain who qualifies for and how to request assistance and reimbursements from the Employer-at-Injury Program.

(b) The Employer-at-Injury Program encourages the early return to work of injured workers by providing incentives from the Workers' Benefit Fund to employers.

(c) The Employer-at-Injury Program is activated by the employer and administered by the insurer.

(d) The purpose of Employer-at-Injury Program assistance is to:

(A) Enable the worker to perform transitional work within the worker's limitations that resulted in the worker's eligibility for the Employer-at-Injury Program;

(B) Prevent a worsening of the worker's compensable injury or occupational disease; or

(C) If the claim has not been accepted or denied, prevent a worsening of the claimed workers' compensation injury or occupational disease.

(2) Applicability.

(a) These rules apply to:

(A) All individual employer-at-injury programs started on or after the effective date of these rules, unless otherwise provided in paragraph (B) or (C) of this subsection;

(B) All wage subsidy reimbursement requests when the wage subsidy period began on or after the effective date of these rules; and

(C) All reimbursement requests received by the division on or after the effective date of these rules for worksite modification or program purchases, regardless of when the purchase was made.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 12/17/19 as WCD Admin. Order 19-059, eff. 1/1/20

**436-105-0004 Submitting Documents or Information;
Calculating Time**

(1) Documents submitted to the division may be:

(a) Mailed to the division's mailing address with sufficient postage and placed in the custody of the U.S. Postal Service;

(b) Hand delivered to the division's Salem office;

(c) Faxed, if the document transmitted indicates it has been delivered by fax, is sent to the correct fax number, and indicates the date it was sent; or

(d) Sent by any other method authorized by the director.

(2) Timeliness of documents submitted to the division:

(a) If a document is mailed, it will be considered submitted on the date it is postmarked.

(b) If a document is hand-delivered, it must be delivered during regular business hours and marked as received to be considered submitted on that date.

(c) If a document is faxed, it must be received by 11:59 p.m. Pacific Time to be considered submitted on that date.

(d) Time periods allowed under these rules are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Adopted 12/17/19 as WCD Admin. Order 19-059, eff. 1/1/20

436-105-0005 Definitions

Unless a term is defined in these rules or the context otherwise requires, the definitions of ORS chapter 656 are incorporated by reference and made part of these rules.

(1) "**Client**" means a person to whom workers are provided under contract and for a fee on a temporary or leased basis.

(2) "**Director**" means the director of the Department of Consumer and Business Services, or the director's designee.

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

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(4) **"Employer at injury"** means the organization that employed the worker when the worker:

- (a) Sustained the injury or occupational disease;
- (b) Made the claim for aggravation; or
- (c) Requested an Own Motion opening under ORS 656.278.

(5) **"Insurer"** means the insurance company or self-insured employer responsible for the workers' compensation claim.

(6) **"Premium"** means the moneys paid to an insurer for the purpose of purchasing workers' compensation insurance.

(7) **"Regular work"** means the job the worker held at the time of injury, claim for aggravation, or Own Motion opening under ORS 656.278.

(8) **"Skills building"** means a class or course of instruction taken by the worker for the purpose of enhancing an existing skill or developing a new skill.

(9) **"Transitional work"** means temporary work with the employer at injury that is not the worker's full-duty regular work and is assigned because the worker cannot perform full-duty regular work.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 12/17/19 as WCD Admin. Order 19-059, eff. 1/1/20

436-105-0006 Workers' Benefit Fund

(1) The department maintains the financial integrity of the Workers' Benefit Fund under ORS 656.605 and all reimbursement is subject to the availability of funds. If the funds are too low for all reimbursements, the director has the final authority to determine how the funds will be disbursed.

(2) Moneys in the Workers' Benefit Fund may not be used to provide concurrent benefits under the Employer-at-Injury Program and the Preferred Worker Program under OAR 436-110 for the same worker for the same period of time, with the exception of claims costs reimbursed under OAR 436-110-0330.

(3) The director may use moneys from the Workers' Benefit Fund for activities to provide information about and encourage the re-employment of injured workers. A maximum of \$250,000 may be used in a fiscal year, July 1 to June 30. The director must approve all expenditures. Activities include, but are not limited to:

- (a) Advertisements and promotion of re-employment assistance programs and associated production costs; and
- (b) Public re-employment assistance program conferences and workshops.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 12/17/19 as WCD Admin. Order 19-059, eff. 1/1/20

436-105-0008 Denial of Reimbursement, Reconsideration, Director's Review

(1) **Denial of reimbursement.** The director will deny any reimbursement for Employer-at-Injury Program assistance it finds violates these rules. The director has the discretion to deny any reimbursement of Employer-at-Injury Program

assistance it determines is not reasonable, practical, or feasible, or considers an abuse of the program.

(2) Reconsideration.

(a) Parties directly affected by an Employer-at-Injury Program decision may request reconsideration by submitting a written request to the division no later than 60 days after the date the decision was issued.

(b) The request must specify the reasons why reconsideration is being requested and may include additional documentation.

(c) The director will reconsider the decision and will notify all directly affected parties of its decision upon reconsideration.

(d) Reconsideration must precede a director's review under section (3) of this rule.

(3) Director's review.

(a) Parties affected by the reconsideration may request a director's review by submitting a written request to the division no later than 60 days after the date the reconsideration was issued. The request must specify the reasons why the decision is appealed and may include additional documentation.

(b) The director may require any affected party to provide information or to participate in the director's review. If the party requesting the director's review fails to participate without reasonable cause as determined by the director, the director may dismiss the review.

(c) The director's review decision will be issued in writing. The director's review decision is final and not subject to further review by any court or other administrative body.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 12/17/19 as WCD Admin. Order 19-059, eff. 1/1/20

436-105-0500 Insurer Participation in the Employer-At-Injury Program

(1) **Insurer participation.** An insurer must be an active participant in providing re-employment assistance under the Employer-at-Injury Program with the employer's consent. Participation includes issuing notices of the available assistance and administering the Employer-at-Injury Program as specified in these rules.

(2) **Notice of assistance available.** The insurer must notify the worker and employer at injury in writing of the assistance available from the Employer-at-Injury Program. A notice must be issued:

- (a) Upon acceptance or reopening of a claim; and
- (b) Within five days of a worker's first release for work after claim opening unless the release is for regular work.

(3) Required notice language.

(a) The notice to the worker required by section (2) of this rule must be in bold type and contain the following language:

The Employer-at-Injury Program provides Oregon's qualified injured workers help with staying on the job or getting back to work. Because of your injury, your employer may be eligible for assistance to return you to transitional work through this program while your claim is

open. Your employer may contact [insurer name and phone number].

(b) The notice to the employer at injury required by section (2) of this rule must be in bold type and contain the following language:

Because of your worker's injury, you may be eligible for assistance through the Employer-at-Injury Program to return the worker to transitional work while the worker's claim is open. To learn more about the assistance available from the program, please call [insurer name and phone number].

(4) **Insurer administration of program.** The insurer must administer the Employer-at-Injury Program according to these rules. The insurer must assist an employer to:

(a) Get a medical release from the medical service provider that meets the requirements of section (5) of this rule;

(b) Identify a transitional work position:

(A) The transitional work position must be within the worker's injury-caused limitations and may be created through modification of the worker's regular work, job restructuring, assistive devices, worksite modification, reduced hours, or reassignment to another job;

(B) Unless the transitional work is skills building, the position must be within the employer's course and scope of trade or profession; and

(C) When skills building is the transitional work, the worker must agree in writing to take the class or course of instruction;

(c) Process employer wage subsidy requests as specified in OAR 436-105-0520(2);

(d) Make worksite modification purchases as specified in OAR 436-105-0520(3);

(e) Make Employer-at-Injury Program purchases as specified in OAR 436-105-0520(4); and

(f) Request Employer-at-Injury Program reimbursement from the division as specified in OAR 436-105-0540.

(5) Medical releases.

(a) Medical releases are required for purposes of the Employer-at-Injury Program.

(b) A medical release must be related to the compensable injury or occupational disease or, if the claim has not been accepted or denied, the claimed workers' compensation injury or occupational disease.

(c) A medical release must:

(A) State the worker's specific current or projected restrictions; or

(B) Indicate the worker is not released to regular work and be accompanied by an approval of a job description that includes the job duties and physical demands required for the transitional work.

(d) A medical release that releases the worker to part-time work or fewer hours than the worker normally worked before the injury must specify the worker's hourly restrictions.

(e) A medical release must be dated and cover any period of time for which benefits are requested.

(A) The date a medical release is issued is considered the effective date if an effective date is not otherwise specified.

(B) A medical release, and any restrictions it contains, remains in effect until another medical release is issued.

(C) If a medical release does not specify an end date or follow-up date and no subsequent medical release is issued, and there is no indication that the worker followed up with the medical service provider, the medical release is effective for no more than 30 days.

(f) An employer or insurer may get clarification about a medical release from the medical service provider who issued the release any time before submitting the reimbursement request.

(6) **Required documentation.** The insurer must maintain all records and documentation of the Employer-at-Injury Program for a period of three years from the date of the last Employer-at-Injury Program reimbursement request. All documentation must be prepared before reimbursement is requested from the division. The insurer must maintain the following information at an authorized claim processing location:

(a) The worker's claim file;

(b) Documentation from the worker's medical service provider that the worker is unable to perform regular work due to the injury and dated copies of all work releases from the worker's medical service provider;

(c) Documentation of the transitional work that includes the start date, wage and hours, and a description of the job duties;

(d) A legible copy of the worker's payroll records for the wage subsidy period;

(A) Payroll records must include:

(i) The date of payment;

(ii) The dates of work covered by the payment;

(iii) The rate or rates of pay;

(iv) Gross wages;

(v) Whether the worker is paid by the hour, shift, day, or week or on a salary, piece, or commission basis;

(vi) The regular hourly rate or rates of pay, the number of regular hours worked, and pay for those hours;

(vii) The number of overtime hours worked, if any, and pay for those hours; and

(viii) The overtime rate or rates of pay;

(B) Payroll records may be supplemented with documentation of how the worker's earnings were calculated for the wage subsidy. Supplemental documentation may be used to determine a worker's work schedule, wages earned on a particular day, dates of paid leave, or to clarify any other necessary information not fully explained by the payroll record; and

(C) If neither the payroll records nor supplemental documentation show the amount of wages earned by the worker

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for reimbursable partial payroll periods, the allowable reimbursement amount may be calculated as follows:

(i) Divide the gross wages by the number of days in the payroll period for the daily rate; and

(ii) Multiply the daily rate by the number of eligible days;

(e) Documentation of the time of the appointment and hours and wages of transitional work for any days for which a partial day's reimbursement is requested after the worker is released for transitional work, or before returning from a medical appointment with a regular work release;

(f) A legible copy of proof of purchase that shows an item for a worksite modification or Employer-at-Injury Program purchase was ordered during the Employer-at-Injury Program period, and proof of payment;

(g) Documentation of the insurer's approval of worksite modifications;

(h) Documentation that payments for a home care worker or personal support worker were made to the Oregon Department of Human Services or Oregon Health Authority, if applicable;

(i) Written acceptance by the worker when skills building is the transitional work; and

(j) Documentation, including course title and curriculum for a class or course of instruction, when Employer-at-Injury Program purchases are requested.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 12/17/19 as WCD Admin. Order 19-059, eff. 1/1/20

436-105-0510 Employer Eligibility

To be eligible for the Employer-at-Injury Program, an employer must:

(1) Maintain Oregon workers' compensation insurance coverage;

(2) Be the employer at injury; and

(3) Employ an eligible worker.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-056, eff. 1/1/17

436-105-0511 Worker Eligibility

To be eligible for the Employer-at-Injury Program, a worker must have an Oregon workers' compensation injury or occupational disease claim at the time of the Employer-at-Injury Program. Adults in custody eligible for benefits under ORS 655.505 to 655.555 and OAR 125-160 are not eligible for the Employer-at-Injury Program.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 12/17/19 as WCD Admin. Order 19-059, eff. 1/1/20

436-105-0512 End of Eligibility

Employer-at-Injury Program eligibility ends at the earliest of any of the following:

(1) When the worker or employer no longer meets the eligibility provisions stated in OAR 436-105-0510 and 436-105-0511;

(2) When the worker's claim is closed or denied;

(3) When sanctions issued under OAR 436-105-0560 preclude eligibility;

(4) When the insurer ends the Employer-at-Injury Program at any time while the worker's claim is open;

(5) Two years after the original date of acceptance of a nondisabling claim; or

(6) When Preferred Worker Program benefits under OAR 436-110 begin for the same claim during the same claim opening, including premium exemption but excluding claims costs reimbursed under OAR 436-110-0330.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-056, eff. 1/1/17

436-105-0520 Assistance Available from the Employer-at-Injury Program

(1) General provisions.

(a) The Employer-at-Injury Program may be used only once per worker per claim opening or request for reopening. If a nondisabling claim becomes a disabling claim after one year from the date of acceptance, the disabling claim is considered a new opening and the Employer-at-Injury Program may be used again.

(b) Assistance available includes wage subsidy, worksite modification, and purchases.

(c) Any modification and other purchases must be ordered before the end of the Employer-at-Injury Program.

(2) **Wage subsidy.** Wage subsidy provides reimbursement of 50 percent of the worker's gross wages for the wage subsidy period. Wage subsidy benefits are subject to the following conditions:

(a) A wage subsidy may not exceed 66 workdays and must be completed within a 24-consecutive month period;

(b) A wage subsidy may not start or end with paid leave;

(c) If the worker has hourly restrictions, reimbursable paid leave cannot exceed the maximum number of hours of the worker's hourly restrictions. Paid leave exceeding the worker's hourly restrictions will not be reimbursed; and

(d) Any day during which the worker exceeds their injury-caused limitations will not be reimbursed. If, however, an employer uses a time clock, a reasonable time of up to 30 minutes per day will be allowed for the worker to get to and from the time clock and the worksite without exceeding the worker's hourly restrictions.

(3) Worksite modification.

(a) Worksite modification is altering a worksite by renting, purchasing, modifying, or supplementing equipment to:

(A) Enable a worker to perform the transitional work within the worker's limitations that resulted in the worker's Employer-at-Injury Program eligibility;

(B) Prevent a worsening of the worker's compensable injury or occupational disease; or

(C) If the claim has not been accepted or denied, to prevent a worsening of the claimed workers' compensation injury or occupational disease.

(b) For purposes of the Employer-at-Injury Program, a "worksite" is a primary work area available for a worker to use to perform the required job duties. The worksite may be the employer's, client's, or worker's premises, property, or equipment used to conduct business under the employer's or client's direction and control. A worksite may include a worker's personal property or vehicle if required to perform the job.

(c) Worksite modification assistance is subject to the following conditions:

(A) The insurer must determine the appropriate worksite modifications for the worker;

(B) The insurer must document its reasons for approving the modifications; and

(C) Worksite modification items become the employer's property at the end of the Employer-at-Injury Program.

(4) Employer-at-Injury Program purchases. Employer-at-Injury Program purchases are limited to:

(a) Tuition, books, fees, and materials required for skills building or to meet the requirements of the transitional work position. Maximum expenditure is \$1,000. Tuition, books, fees, and required materials will be provided under the following conditions:

(A) The insurer must determine the class or course of instruction will help the worker enhance an existing skill or develop a new skill, and must document its decision; and

(B) The worker must begin participation in the class or course of instruction while eligible for the Employer-at-Injury Program;

(b) Clothing required for the job, except clothing the employer normally provides. Clothing becomes the worker's property. Maximum expenditure is \$400; and

(c) Tools and equipment required for the worker to perform transitional work, including consumables required to support the functioning of the tools or equipment. These purchases become the employer's property.

(5) Other conditions for worksite modifications and purchases.

(a) Worksite modification and purchases of tools and equipment are limited to a combined maximum reimbursement of \$5,000.

(b) Extended warranties that are in addition to the standard or manufacturer's warranty are not reimbursable under the Employer-at-Injury Program.

(c) All modifications and purchases made by the employer in good faith are reimbursable, even if the worker refuses to return to work, or if the worker agreed to take part in training and then later refused to attend training.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 12/17/19 as WCD Admin. Order 19-059, eff. 1/1/20

Amended 6/13/22 as Admin. Order 22-058, eff. 7/1/22

436-105-0530 Employer-at-Injury Program Procedures for Concurrent Injuries

(1) A worker is eligible for only one Employer-at-Injury Program at a time.

(2) When a worker in an Employer-at-Injury Program incurs a new compensable injury, transitional work for the first Employer-at-Injury Program is considered regular work for purposes of the second Employer-at-Injury Program.

(3) If the new injury makes the first Employer-at-Injury Program unsuitable, the worker may be eligible for a second Employer-at-Injury Program under the new injury.

(4) When the worker is no longer eligible for the second Employer-at-Injury Program, the first Employer-at-Injury Program may be resumed if the employer and worker still meet eligibility criteria under that claim.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-056, eff. 1/1/17

436-105-0540 Employer-at-Injury Program Reimbursement Procedures

The following provisions apply when the insurer requests reimbursement from the division under the Employer-at-Injury Program:

(1) **Reimbursable benefits.** Reimbursements may include wage subsidy, Employer-at-Injury Program purchases, and worksite modification.

(2) **Program administrative costs.** The insurer is entitled to a program administrative cost of \$180 for the first approved reimbursement request for an Employer-at-Injury Program. Subsequent requests for reimbursement, including amended requests, for the same Employer-at-Injury Program are not entitled to additional program administrative costs.

(3) **Minimum reimbursement request.** The first reimbursement request for an Employer-at-Injury Program must be for a minimum of \$100. Subsequent requests, including amended requests, may be for less than \$100.

(4) **Required documentation.** The insurer must have all documentation required for reimbursement in its possession at the time reimbursement is requested. The insurer must stamp or display evidence of the initial date of receipt on each document as required under OAR 436-060-0017(2).

(5) Timeframe for submitting a reimbursement request and required documentation.

(a) The employer must submit all required documentation for reimbursement to the insurer within one year from the end of the Employer-at-Injury Program.

(b) The insurer must submit to the division within one year and 30 days from the end of the Employer-at-Injury Program:

(A) [Form 2360](#), "Employer-at-Injury Program (EAIP) Reimbursement Request Form." The form is published with [Bulletin 260](#), both of which are available on the division's website at wcd.oregon.gov; and

(B) For EAIP purchases and worksite modifications:

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(i) Documentation of the transitional work that includes the start date, wage and hours, and a description of the job duties;

(ii) The corresponding medical release that the transitional work was based on;

(iii) A legible copy of proof of any purchase showing the item was ordered during the Employer-at-Injury Program period and proof of payment for the item; and

(iv) Documentation of the insurer's approval of any worksite modifications.

(6) Corrected request forms. If the reimbursement request form is incomplete or contains an error, the division may return the form to the insurer for correction. The insurer has 60 days from the date it receives the returned reimbursement request form from the division, or one year and 30 days from the end of Employer-at-Injury Program eligibility, whichever is later, to make the corrections and return the corrected form to the division.

(7) Amended requests.

(a) Amended reimbursement requests must be submitted to the division within one year and 30 days from the end of the Employer-at-Injury Program eligibility except as otherwise permitted in this rule.

(b) An amended reimbursement request must clearly state that it is an amendment and clearly state the corrected information.

(8) Denied claims.

(a) The insurer may request reimbursement when a claim that was initially denied is subsequently accepted after the Employer-at-Injury Program eligibility ended and more than one year and 30 days have passed. In that case, the insurer must submit a completed [Form 2360](#), "Employer-at-Injury Program (EAIP) Reimbursement Request Form," with the documentation specified in (5)(b) of this rule to the division within 60 days of the first litigation order or stipulation and order accepting the claim. A copy of the order or stipulation must be attached to the reimbursement request form.

(b) The insurer may request reimbursement for a qualifying Employer-at-Injury Program that took place before a claim denial even if the claim is denied at the time the insurer submits the request to the division.

(9) Effect on rates, dividends, premiums, or assessments.

The insurer may not use Employer-at-Injury Program costs subject to reimbursement for rate making, individual employer rating, dividend calculations, or in any manner that would affect the employer's insurance premiums or premium assessments under ORS 656.612 and OAR 436-085 with the present or a future insurer. The insurer must be able to document that Employer-at-Injury Program costs do not affect the employer's rates or dividend.

(10) Claim costs. If a preferred worker employed by an eligible employer with active premium exemption under OAR 436-110-0325 incurs a new injury, the claim is subject to claim costs reimbursement under OAR 436-110-0330. If the worker subsequently begins an Employer-at-Injury Program, program

costs must be separated from claim costs and will not be reimbursed as claim costs.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 12/17/19 as WCD Admin. Order 19-059, eff. 1/1/20

Amended 11/5/21 as WCD Admin. Order 21-057, eff. 1/1/22

436-105-0550 Audits

(1) Insurers and employers are subject to periodic program and fiscal audits by the director. All reimbursements are subject to subsequent audits, and may be disallowed on any of the grounds set forth in these rules. Disallowed reimbursements may be recovered by the director directly or from future reimbursements by way of offset. If the director finds upon audit that procedures that led to disallowed reimbursements are still being used, the director may withhold further reimbursements until corrections satisfactory to the director are made.

(2) An audit may include but not be limited to a review of the records required in OAR 436-105-0500(6).

(3) When there is conflicting documentation, the director will use a preponderance of evidence standard to decide eligibility for reimbursement. If there is no clear preponderance, reimbursement will be denied.

(4) The director reserves the right to visit the worksite to determine compliance with these rules.

Statutory authority: ORS 656.455, 656.622, 656.726(4), 731.475

Statutes implemented: ORS 656.455, 656.622, 731.475

Hist: Amended 11/28/16 as WCD Admin. Order 16-056, eff. 1/1/17

436-105-0560 Sanctions

(1) Penalties for false statement or report or misrepresentation. Any person who knowingly makes a false statement or misrepresentation to the director or an employee of the director for the purpose of obtaining any benefits or reimbursement from the Employer-at-Injury Program, or who knowingly misrepresents the amount of a payroll or knowingly submits a false payroll report, is subject to penalties under ORS 656.990.

(2) Reasons for sanction. Reasons for the director to sanction an insurer, self-insured employer, employer, or their representative include, but are not limited to:

(a) Misrepresenting information in order to receive Employer-at-Injury Program assistance;

(b) Making a serious error or omission that resulted in the director approving reimbursement in error;

(c) Failing to respond to employer requests for assistance or failing to administer Employer-at-Injury Program assistance; or

(d) Failing to comply with any condition in these rules.

(3) Possible sanctions. The director may order one or more of the following sanctions:

(a) Ordering the person to take corrective action within a specific period of time;

(b) Ordering the person being sanctioned to repay the department all, or part, of the moneys reimbursed, with or without interest at a rate set by the department;

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(c) Ending the employer's eligibility to use the Employer-at-Injury Program for a specific period of time; or

(d) Pursuing civil penalties under ORS 656.745 or criminal action against the party.

Statutory authority: ORS 656.622, 656.726(4)
Stat. Implemented: ORS 656.622, 656.745, 656.990
Hist: Amended 12/17/19 as WCD Admin. Order 19-059, eff. 1/1/20

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**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 110
PREFERRED WORKER PROGRAM**

Effective July 1, 2022

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436-110-0003 Purpose and Applicability of These Rules

(1) Purpose.

(a) The rules in OAR 436-110 explain who qualifies for and how to request assistance and reimbursements from the Preferred Worker Program.

(b) The Preferred Worker Program encourages the re-employment of workers whose on-the-job injuries result in disability that may be a substantial obstacle to employment by providing assistance from the Workers' Benefit Fund to eligible injured workers and to the employers who employ them.

(c) The Preferred Worker Program is activated by the worker or by the employer at injury.

(2) Applicability.

These rules apply to all requests for Preferred Worker Program re-employment assistance received by the division on or after the effective date of these rules.

(3) Submitting documents or information, calculating time.

(a) Documents or information required under these rules to be submitted to the division may be submitted in any of the following ways:

(A) Mailed to the division's mailing address with sufficient postage and placed in the custody of the U.S. Postal Service;

(B) Physical delivery to the division's Salem office;

(C) Faxed, if the document transmitted indicates it has been delivered by fax, is sent to the correct fax number, and indicates the date it was sent; or

(D) Any other method authorized by the director.

(b) Timeliness under these rules is determined as follows:

(A) If a document is mailed, it will be considered submitted on the date it is postmarked.

(B) If a document is delivered, it must be delivered during regular business hours and marked as received to be considered submitted on that date.

(C) If a document is faxed, it must be received by 11:59 p.m. Pacific Time to be considered submitted on that date.

(c) Time periods allowed under these rules are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

(4) Availability of forms.

The bulletins and forms referenced in these rules are available on the division's website at wcd.oregon.gov.

(5) Director's discretion.

The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0005 Definitions

For the purpose of these rules, unless the context requires otherwise:

(1) "**Client**" means a person to whom workers are provided under contract and for a fee on a temporary or leased basis.

(2) "**Date of eligibility**" means the date the director determines a worker is a preferred worker.

(3) "**Date of hire**" means the date the worker starts work as a preferred worker.

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

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(5) **"Director"** means the director of the Department of Consumer and Business Services, or the director's delegate for the matter.

(6) **"Disability"** means a permanent physical or mental restriction or limitation caused by an accepted disabling Oregon workers' compensation claim that limits the worker from performing one or more of the worker's regular job duties.

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

(8) **"Employer at injury"** means the organization that employed the worker when the worker sustained the injury or occupational disease.

(9) **"Exceptional disability"** means a disability equal to or greater than the complete loss, or loss of use, of both legs or a brain injury that results in impairment equal to or greater than a Class 3 under OAR 436-035-0390(10). The director determines whether a worker has an exceptional disability based upon the combined effects of all of the worker's Oregon compensable injuries resulting in permanent disability.

(10) **"Fund"** means the Workers' Benefit Fund under ORS 656.605.

(11) **"Insurer"** means the insurance company or self-insured employer responsible for the workers' compensation claim.

(12) **"Premium"** means the monies paid to an insurer for the purpose of purchasing workers' compensation insurance.

(13) **"Premium assessment"** means monies due the director under ORS 656.612 and 656.614.

(14) **"Regular work"** means the job the worker held at the time of the injury, claim for aggravation, or Own Motion opening under ORS 656.278.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0006 Workers' Benefit Fund

(1) The department maintains the financial integrity of the fund and all reimbursement is subject to the availability of funds. If the funds are too low for all reimbursements, the director has final authority to determine how the funds will be disbursed.

(2) Monies in the Workers' Benefit Fund may not be used to provide concurrent benefits under the Preferred Worker Program and the Employer-at-Injury Program under OAR 436-105 for the same worker for the same period of time, with the exception of claims costs reimbursed under OAR 436-110-0330.

(3) The director may use monies from the fund for activities to provide information about and encourage re-employment of injured workers. A maximum of \$250,000 may be used in a fiscal year, July 1 to June 30. The director must approve all expenditures. Activities include, but are not limited to:

(a) Advertisements and promotion of re-employment assistance programs and associated production costs; and

(b) Public re-employment assistance program conferences and workshops.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0007 Denial of Requests, Reconsideration, Director's Review

(1) Denial of requests for assistance.

The director will deny any request for Preferred Worker Program assistance it finds violates these rules. The director has the discretion to deny a request it determines is not reasonable, practical, or feasible, or considers an abuse of the program.

(2) Reconsideration.

(a) Parties directly affected by a Preferred Worker Program decision of the director may request reconsideration by submitting a written request to the division no later than 60 days after the date the decision was issued.

(b) The request for reconsideration must specify the reasons why the decision is appealed and may include additional documentation.

(c) The director will reconsider the decision and will notify all directly affected parties of its decision upon reconsideration.

(d) Reconsideration must precede a director's review under section (3) of this rule.

(3) Director's review.

(a) If, upon reconsideration, the director upholds the original decision, it will be referred for director's review. A party does not need to request director's review.

(b) The director may require any affected party to provide information or to participate in the director's review. If the party requesting the director's review fails to participate without reasonable cause as determined by the director, the director may dismiss the review.

(c) The director's review decision will be issued in writing. The director's review decision is final and not subject to further review by any court or other administrative body.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0150 Pilot Projects

(1) The director may develop one or more pilot projects to test alternatives to the current system of re-employing preferred workers.

(2) Notwithstanding any other provision of these rules, the director and others participating in pilot projects are bound by the terms of the pilot project.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0240 Insurer Participation in the Preferred Worker Program

(1) Insurer participation.

The insurer of the employer at injury must be an active participant in providing re-employment assistance under the Preferred Worker Program.

(2) Notice of assistance available.

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The insurer must notify the worker and employer at injury in writing of the assistance available from the Preferred Worker Program. A notice must be issued:

(a) Within five days of the worker being declared medically stationary;

(b) Upon determination of the worker's eligibility or ineligibility for vocational assistance under ORS 656.340 and OAR 436-120; and

(c) Upon approval of a claim disposition agreement.

(3) Required notice language.

(a) The notice to the worker required by section (2) of this rule must be in bold type and contain the following language:

The Preferred Worker Program helps Oregon's injured workers get back to work. To find out whether you qualify, contact the Preferred Worker Program.

Call: 503-947-7588 or 800-445-3948 (toll-free)

Fax: 503-947-7581

Or write the Preferred Worker Program at P.O. Box 14480, Salem, Oregon 97309-0405 or pwp.oregon@dcbs.oregon.gov.

(b) The notice to the employer at injury required by section (2) of this rule must be in bold type and contain the following language:

As the employer of an injured worker, you may be eligible for valuable Preferred Worker Program incentives if the worker cannot return to regular work and has permanent restrictions caused by the injury.

If the worker's Preferred Worker Program eligibility has not been determined, you may contact the Workers' Compensation Division for an eligibility review.

To be eligible for exemption from paying workers' compensation premiums for this worker for three years, you must:

Bring back your preferred worker to a new or modified job; and

Notify the Workers' Compensation Division within 90 days of the date the worker is determined eligible or within 90 days of the date you bring the worker back to work, whichever is later.

To request all other Preferred Worker Program benefits, you must contact the Workers' Compensation Division within 180 days of the worker's claim closure date.

To find out more about the Preferred Worker Program, contact the program.

Call: 503-947-7588 or 800-445-3948 (toll-free)

Fax: 503-947-7581

Or write the Preferred Worker Program at P.O. Box 14480, Salem, Oregon 97309-0405 or pwp.oregon@dcbs.oregon.gov

(4) Reporting information to the division.

The insurer must provide the division with preferred worker information upon the following:

(a) Claim closure according to ORS 656.268, by submitting [Form 1503](#), "Insurer Notice of Closure Summary," as prescribed by OAR 436-030-0015(1);

(b) Within 30 calendar days of an order on reconsideration, opinion and order of an administrative law judge, order on review by the board, decision of the Court of Appeals or Supreme Court, or stipulation between the parties that grants initial permanent disability after the latest opening of the worker's claim; and

(c) Approval of a claim disposition agreement, if documented medical evidence indicates permanent restrictions exist as a result of the injury or disease, and the worker is unable to return to regular work. If a claim disposition agreement is approved before the worker is medically stationary, the insurer must continue to process the claim to medically stationary for purposes of the Preferred Worker Program.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622; 656.726(4)

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

Amended 11/24/21 as WCD Admin. Order 21-058, eff. 1/1/22

436-110-0290 Employer at Injury Use of the Preferred Worker Program

The conditions for the employer at injury to activate the Preferred Worker Program are:

(1) Time frame.

(a) For Preferred Worker Program assistance other than premium exemption, the employer at injury must request Preferred Worker Program assistance from the division within 180 days of the worker's claim closure date, except as provided in subsection (1)(c).

(b) Conditions for employer at injury activated premium exemption are provided in OAR 436-110-0325.

(c) When worksite modifications are provided, and the modifications are completed and verified by the director more than 150 days after the worker's claim closure date, the employer at injury will have 30 calendar days from the verification date to request other assistance.

(2) Job offer.

The worker must agree to accept the new or modified regular job with the employer at injury in writing. [Form 4903](#), "Preferred Worker Job Offer Letter," is a sample job offer letter. The job offer must include:

(a) The start date, which is the date the worker begins receiving payment for the new or modified job. If the job starts after the modifications are in place, so note;

(b) Wage and hours;

(c) Job site location; and

(d) Description of job duties that includes physical requirements.

(3) Additional modifications.

If the employer at injury uses worksite modification assistance and the employer or worker later requests additional modifications for the same job, the employer at injury's

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worksites modification benefit will be exhausted before using the worker's worksites modification benefits.

Statutory authority: ORS 656.726(4), 656.622

Statutes implemented: ORS 656.622

Hist.: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0310 Eligibility and End of Eligibility for the Preferred Worker Program

(1) Employer eligibility.

The eligibility requirements for the Preferred Worker Program for an employer, including the employer at injury, except as provided in OAR 436-110-0345(1) for employment purchases, are:

(a) The employer has and maintains Oregon workers' compensation insurance coverage;

(b) The employer complies with the Oregon workers' compensation law;

(c) The employer must offer or provide employment to an eligible preferred worker who is a subject Oregon worker according to ORS 656.027;

(d) If the employer is a worker leasing company, it must be licensed with the director under ORS 656.850; and

(e) The employer is not currently ineligible for preferred worker benefits under OAR 436-110-0900.

(2) Worker eligibility.

The eligibility requirements for a worker for the Preferred Worker Program are:

(a) The worker has an accepted disabling Oregon compensable injury or occupational disease. Adults in custody eligible for benefits under ORS 655.505 to 655.555 and OAR 125-160 are not eligible;

(b) The worker will not be able to return to regular work, as indicated by medical evidence and due to injury-caused restrictions, under any claim opening;

(c) Medical documentation indicates permanent restrictions exist as a result of the injury or disease, whether or not an order has been issued awarding permanent disability;

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

(e) The worker complies with the Oregon workers' compensation law.

(3) Work experience program participants, apprentices, and trainees.

(a) Individuals covered under ORS 656.033, 656.046, 656.135, or 656.138, are eligible for the Preferred Worker Program if they otherwise meet the eligibility requirements in section (2) of this rule.

(b) For purposes of the Preferred Worker Program, for individuals covered under ORS 656.033, 656.046, 656.135, or 656.138, the job for which the individual was being trained is considered regular work.

(4) Self-employment.

A worker may not use preferred worker benefits for self-employment unless the injury that gave rise to the worker's eligibility for the Preferred Worker Program occurred in the

course and scope of self-employment. In that case, the worker may use the benefits to return to the same self-employment or for employment other than self-employment.

(5) Ending eligibility.

Reasons for ending Preferred Worker Program eligibility include, but are not limited to, the following:

(a) Misrepresentation or omission of information by a worker or employer to obtain assistance;

(b) Failure of a worker or employer to provide requested information or cooperate;

(c) Falsification or alteration of a preferred worker card or a Preferred Worker Program agreement;

(d) Conviction of fraud in obtaining workers' compensation benefits;

(e) The worker no longer meets the eligibility requirements under section (2) of this rule; or

(f) The employer no longer meets the eligibility requirements under section (1) of this rule.

(6) Reinstatement of eligibility.

The director retains the right to reinstate Preferred Worker Program eligibility if eligibility was ended prematurely or in error, or if the employer has reinstated or obtained workers' compensation insurance coverage.

(7) Redetermination of eligibility.

A worker found ineligible because the worker was not authorized to work in the United States may request a redetermination of eligibility after providing the division with documentation that the worker is authorized to work in the United States.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 12/17/19 as Admin. Order 19-067, eff. 1/1/20

436-110-0320 Preferred Worker Card

(1) The division will issue a preferred worker card to eligible workers. The card identifies a worker as being eligible to offer an employer Preferred Worker Program assistance.

(2) The division will issue a preferred worker card:

(a) Automatically at the time of claim closure based upon insurer submission of preferred worker information as specified in OAR 436-110-0240(4)(a); or

(b) When the division determines the worker is eligible for the Preferred Worker Program.

(3) The division may inactivate a preferred worker card if:

(a) The card was issued in error; or

(b) Any reason for ending Preferred Worker Program eligibility as specified in OAR 436-110-0310(5) applies.

Statutory authority: ORS 656.622, 656.726(4)

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0325 Premium Exemption

(1) General provisions.

(a) The purpose of premium exemption is to provide an incentive for employers to hire and retain preferred workers.

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(b) Premium exemption releases an employer from paying workers' compensation insurance premiums and premium assessments on a preferred worker for three years from the date premium exemption started. When premium exemption is in place, the employer does not report, and the insurer may not use, the preferred worker's payroll for the calculation of insurance premiums or premium assessments. However, the employer must report and pay the Workers' Benefit Fund assessment and withhold employee contributions as required by ORS 656.506 and OAR 436-070. The employer must start paying insurance premiums and premium assessments when premium exemption ends.

(2) Employer eligibility.

To be eligible for premium exemption the employer must:

(a) Hire a preferred worker or, for the employer at injury or aggravation, bring back its preferred worker to a new or modified job; and

(b) Notify the division within 90 days from the date of eligibility or the date of hire, whichever is later.

(3) Exclusion.

Premium exemption may not be used if the worker has permanent restrictions but returns to regular work.

(4) Division notification.

(a) The employer must notify the division within 90 days from the date of eligibility or the date of hire, whichever is later.

(b) If the director approves premium exemption, the division will notify the employer and insurer of the premium exemption period.

(c) If the director does not approve premium exemption, the division will notify the employer.

(5) Premium exemption period.

(a) For the employer at injury or aggravation, premium exemption starts on the date of hire or the date of eligibility, whichever is later.

(b) If the employer is not the employer at injury or aggravation, the worker discloses preferred worker status to that employer, and the employer notifies the division within 90 days from the date of hire that it has hired a preferred worker, premium exemption starts on the date of hire.

(c) The three-year premium exemption period may not be extended, even if the preferred worker's job duties change or the employer's ownership or legal status changes.

(6) Claims costs.

If a worker covered under premium exemption incurs a compensable injury or occupational disease during the premium exemption period, the employer must notify its insurer of the injury and the worker's preferred worker status. The claim costs for the injury are reimbursed under OAR 436-110-0330.

Statutory authority: ORS 656.726(4), 656.622

Statutes implemented: ORS 656.622

Hist.: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0330 Claim Cost Reimbursement

(1) General provisions.

Claim cost reimbursement provides reimbursement to the insurer for claim costs when a preferred worker files a claim for injury or occupational disease while employed under premium exemption as follows:

(a) Reimbursements will be made for the life of the claim;

(b) Reimbursable claim costs include disability benefits, medical benefits, vocational costs under OAR 436-120-0720, claim disposition agreements under ORS 656.236, disputed claim settlements under ORS 656.289, stipulations, attorney fees awarded the worker or the worker's beneficiaries, and administrative costs;

(c) Reimbursable claim costs for denied claims include costs incurred up to the date of denial, but are limited to benefits the insurer is obligated to pay under ORS chapter 656 and diagnostic tests, including independent medical examinations necessary to determine compensability of the claim;

(d) The administrative cost factor that will apply to claim costs is published in [Bulletin 316](#); and

(e) The claim may not be used for ratemaking, individual employer rating, dividend calculations, or in any manner that would affect the employer's insurance premiums or premium assessments with the present or a future insurer. The insurer must be able to document that claim data will not affect the employer's rates or dividend.

(2) Reimbursement request process.

The insurer must request claim cost reimbursement as follows:

(a) A request for reimbursement must be submitted to the division within 15 months of the date on which payment was made;

(b) The insurer must use [Form 3014](#), "Preferred Worker Program Quarterly Cost Reimbursement Request"; and

(c) Reimbursement documentation must include, but is not limited to:

(A) Net amounts paid. "Net amounts" means the total compensation paid less any recoveries, including, but not limited to, third-party recovery or reimbursement from the Retroactive Program, Reopened Claims Program, or the fund; and

(B) Any other information required by the director.

(3) Costs not reimbursable.

Requests for reimbursement may not include:

(a) Claim costs for any injury that did not occur while the worker was employed with premium exemption;

(b) Costs incurred for conditions completely unrelated to the compensable claim;

(c) Costs incurred due to inaccurate, untimely, unreasonable, or improper processing of the claim;

(d) Penalties, fines, or filing fees;

(e) Disposition amounts in accordance with ORS 656.236 or 656.289 not previously approved by the director;

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(f) Costs reimbursed or outstanding requests for reimbursement from the Reopened Claims Program, Retroactive Program, or the fund; or

(g) Reimbursable Employer-at-Injury Program costs.

(4) Audit, disallowed amounts.

Periodically, the director will audit the insurer's file to validate the amount reimbursed. Reimbursed amounts must be refunded to the division and, as applicable, future reimbursements will be denied if, upon audit, any of the following is found to apply:

(a) Reimbursement has been made for any of the items specified in section (3) of this rule;

(b) If claim acceptance as a new injury rather than an aggravation is questionable and the rationale for acceptance has not been reasonably documented;

(c) The separate payments of compensation have not been documented;

(d) The insurer included claim costs in any dividend or retrospective rating or experience rating calculations; or

(e) The insurer is unable to provide applicable records relating to experience rating, retrospective rating, or dividend calculations at the time of audit or within 14 working days thereafter.

(5) Reinstatement of reimbursement.

If the conditions described in subsections (4)(a) through (e) of this rule are corrected and all other criteria of the rules are met, eligibility for reimbursement may be reinstated. If reimbursement eligibility is reinstated, any monies previously reimbursed and then recovered will be reimbursed again according to these rules.

(6) Reimbursement of settlement amounts.

A claim disposition agreement under ORS 656.236, a disputed claim settlement under ORS 656.289, or any stipulation or agreement of a claim subject to claim cost reimbursement from the fund must meet the following requirements for reimbursement:

(a) The insurer must obtain prior written approval of the agreement from the director. The proposed agreement must be submitted to the division before being submitted to the Workers' Compensation Board or administrative law judge for approval;

(b) A claim's future liability and the proposed contribution from the fund must be a reasonable projection, as determined by the director, in order to be approved for reimbursement from the fund; and

(c) A request for approval of the proposed agreement must include:

(A) A copy of the proposed agreement, containing appropriate signatures and a signature line for director approval, that specifies the proposed assistance from the fund;

(B) A written explanation of how the calculations for the amount of assistance from the fund were made; and

(C) Other information as required by the director.

Statutory authority: ORS 656.726(4), 656.622

Statutes implemented: ORS 656.622

Hist.: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0335 Wage Subsidy General Provisions

Wage subsidy provides an employer with partial reimbursement of a worker's gross wages for a specified period. Wage subsidy benefits are subject to the following conditions:

(1) Wage subsidy agreement form.

A completed [Form 2190](#), "Preferred Worker Wage Subsidy Agreement," must be submitted to the division. Signature and time frame requirements for employer at injury activated wage subsidy are in OAR 436-110-0336(2), and requirements for worker-activated wage subsidy are in OAR 436-110-0337(1).

(2) Effective date.

The effective date of the wage subsidy agreement is mutually agreed to by the director, employer, and worker if applicable.

(3) Time limits, reimbursement rate.

A wage subsidy is limited to a duration of 183 calendar days and a reimbursement rate of 50 percent for the approved period. For a worker with an exceptional disability, a wage subsidy duration is limited to 365 calendar days and a reimbursement rate of 75 percent for the approved period.

(4) Interruption and extension of agreement.

A wage subsidy agreement may be interrupted once for reasonable cause and extended to complete the agreement on a whole workday basis. Reasonable cause includes, but is not limited to, personal or family illness, death in the worker's family, pregnancy of the worker or worker's spouse, a compensable injury to the worker, participation in an Employer-at-Injury Program, or layoff. A layoff must be a minimum of 10 consecutive work days. A period of time during which the employer is without workers' compensation insurance coverage is not reasonable cause and no extension will be granted.

(5) Pay structure.

A preferred worker's pay structure must be the same as the pay structure for other workers employed in similar jobs by the employer.

(6) Prevailing wage.

Wages subject to reimbursement must be within the prevailing wage range for that occupation. The prevailing wage range is determined as follows:

(a) Examine the wages paid by the employer for other workers doing the same job;

(b) If no other workers are doing the same job, a labor market survey of the local labor market may be conducted; and

(c) If the labor market survey does not support the wage rate requested, the director will determine the wage subject to reimbursement.

(7) May not be combined with vocational training.

Preferred Worker Program wage subsidies may not be combined with a wage reimbursement for a training plan under OAR 436-120, "Vocational Assistance to Injured Workers."

(8) Changes in employer.

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If the worker's employer changes during the wage subsidy agreement period due to a sale of the business, incorporation, or merger, the agreement can be transferred to the new employer by an addendum to the agreement approved by the director as long as the worker's job remains the same and the new employer is eligible under OAR 436-110-0310(1).

(9) Reimbursement requests.

(a) A completed and signed [Form 2968](#), "Preferred Worker Program Wage Subsidy Reimbursement Request," must be submitted to the division with a legible copy of the worker's payroll records.

(b) Payroll records must include:

- (A) The date of payment;
- (B) The dates of work covered by the payment;
- (C) The rate or rates of pay;
- (D) Gross wages;
- (E) The regular hourly rate or rates of pay, the number of regular hours worked, and pay for those hours;
- (F) The number of overtime hours worked, if any, and pay for those hours; and
- (G) The overtime rate or rates of pay.

(c) All requests for reimbursement must be made within one year of the wage subsidy agreement end date.

(10) May not be used for regular work.

Wage subsidy may not be used if the worker has permanent restrictions but returns to regular work.

Statutory authority: ORS 656.726(4), 656.622

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0336 Wage Subsidy – Employer at Injury Activated

Wage subsidy may be activated by the employer at injury as follows:

(1) The job must be within the worker's injury-caused restrictions. If a worksite modification is necessary to meet this requirement, wage subsidy will be deferred until:

- (a) The worksite modification is complete; or
- (b) The employer accommodates the worker's injury-caused restrictions while waiting for the worksite modification to be complete.

(2) The employer must complete and sign [Form 2190](#), "Preferred Worker Wage Subsidy Agreement," and submit it to the division in the time frames allowed in OAR 436-110-0290(1).

(3) The completed and signed job offer required in OAR 436-110-0290(2) must accompany the request for wage subsidy benefits, unless it was already submitted with another request.

(4) The employer at injury may use wage subsidy once during an eligibility period.

Statutory authority: ORS 656.726(4), 656.622

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0337 Wage Subsidy – Worker Activated

A wage subsidy may be requested by a worker as follows:

(1) The worker and employer must complete and sign [Form 2190](#), "Preferred Worker Wage Subsidy Agreement," and submit it to the division within three years of the date of hire.

(2) A preferred worker may use wage subsidy as many times as needed, up to a maximum total reimbursement of \$40,000. A worker with an exceptional disability may use wage subsidy twice with no maximum total reimbursement rate. The maximum total reimbursement will be restored if there is a subsequent claim closure, and the worker is unable to return to regular work.

(3) If the employer at injury uses wage subsidy for a job, the worker may not use wage subsidy for the same job.

(4) A worker can use a second wage subsidy with the same employer for a new job if:

- (a) The majority of job duties have changed; and
- (b) At least one year has passed from the end of the first wage subsidy period.

Statutory authority: ORS 656.726(4), 656.622

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0345 Employment Purchases and Placement Services

(1) General provisions.

An employment purchase is assistance necessary for a worker to find, accept, or retain employment in Oregon. Purchases may be provided for a job with a nonsubject employer in Oregon, as long as that employer complies with the appropriate workers' compensation law. Employment purchases may not be used if the worker has permanent restrictions but returns to regular work. Except as provided in subsection (2)(i) of this rule, all purchases become the worker's property.

(2) Types of purchases.

Employment purchases are limited to:

(a) **Tuition, books, and fees** for instruction provided by an educational entity accredited or licensed by an appropriate body in order to update existing skills or to meet the requirements of an obtained job. This category can be used as often as necessary up to a maximum of \$2,000, with each use limited to \$1,000;

(b) **Temporary lodging, meals, and mileage** to attend instruction when overnight travel is required. Reimbursable costs must be incurred within a 30-day period of time. The cost of meals, lodging, public transportation, and use of a personal vehicle will be reimbursed at the rate published in [Bulletin 112](#). This category can be used as often as necessary up to a maximum of \$1,000;

(c) **Tools and equipment** mandatory for employment. Purchases must not include items the worker possesses, duplicate worksite modification items, vehicles, or items needed for worksite creation. This category can be used as often as necessary up to a maximum of \$5,000, with each use limited to \$2,500;

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(d) **Clothing** required for the job. This category can be used as often as necessary up to a maximum of \$1,000, with each use limited to \$500;

(e) **Transportation-related purchases**, not including vehicles or vehicle maintenance, that enable the worker to commute to a job such as, but not limited to, bus fare, gasoline, or repairs to an existing vehicle. This category can be used as often as necessary up to a maximum of \$1,000, requested within 90 days of hire;

(f) **Moving expenses** for a job if the new worksite is in Oregon and 50 or more miles from the worker's primary residence. When the worker's permanent disability from the injury precludes the worker from commuting the required distance, moving expenses may be provided to move within 50 miles of the worker's primary residence or within the distance the worker commuted for work at claim opening. The worker must complete, sign, and submit [Form 3293](#), "Preferred Worker Moving Assistance Agreement." Moving expenses are limited to one use. Expenditure is limited to:

(A) The cost of moving household goods weighing not more than 10,000 pounds and reasonable costs of meals and lodging for the worker. The cost of meals, lodging, public transportation, and use of a personal vehicle will be paid at the rate published in [Bulletin 112](#). Lodging and meals are limited to a maximum period of two weeks. Mileage for one personal vehicle is limited to a single one-way trip; and

(B) Rental allowance for the worker's primary residence limited to first month's rent as specified in the rental agreement, nonrefundable deposit in an amount not to exceed the first month's rent, and a required credit check for that residence;

(g) Initiation fees, or back dues and one month's current dues, required by a **labor union**. This category can be used as often as necessary up to a maximum of \$1,000;

(h) **Occupational certification, licenses, and related testing costs, drug screen testing, physical examinations, or membership fees** required for the job. This category can be used as often as necessary up to a maximum of \$1,000, with each use limited to \$500;

(i) **Worksite creation** costs that are limited to equipment, furnishings, or other things the employer needs to create a new job for the worker. A completed and signed [Form 4122](#), "Preferred Worker Worksite Creation Agreement," must be submitted to the division. All items purchased are the property of the employer. This category can be used as often as necessary up to a maximum of \$10,000, with each use limited to \$5,000; and

(j) **Miscellaneous** purchases that do not fit into subsections (a) through (i) of this section, subject to approval by the director. This category does not include a vehicle purchase. This category can be used as often as necessary up to a maximum of \$2,500.

(3) Payment and reimbursement.

(a) Costs of employment purchases will be paid by reimbursement or by other instrument of payment approved by the director.

(b) The director will provide payment but will not otherwise assume responsibility for employment purchases.

(c) The person or entity that purchased the items may request reimbursement by submitting to the division a legible copy of an invoice or receipt showing payment has been made for the items purchased. Reimbursement will be made for only those items and costs approved and paid.

(d) All requests for reimbursement must be made within one year of the end date on [Form 2350](#), "Preferred Worker Employment Purchase Agreement."

(e) Reimbursed costs may not be charged by the insurer to the employer as claim costs or by any other means.

(4) Placement services.

(a) **Placement assistance services** provided to a preferred worker by a certified vocational counselor or any public or private agency that provides placement services are reimbursable as provided in this section.

(A) Placement assistance services provide the worker with skills to find employment, including, but not limited to, intake, resume writing, interview skills, resource development, online application development, job search skills, job coaching, and employer contacts.

(B) The counselor or agency representative and the worker must complete, sign, and submit to the division [Form 4875](#), "Preferred Worker Placement Assistance Agreement," with an estimate of services to be provided.

(C) Placement assistance is limited to a maximum expenditure of \$1,000 for services described in paragraph (A). Payment for these services is based on a billable hourly rate of \$85 (or at one-half rate for travel) and may be made to the counselor or agency that provided placement services to enable the worker to find employment, regardless of whether the worker finds employment.

(D) Only one placement assistance agreement may be in approved status at any given time.

(E) Placement assistance may not be combined with vocational assistance under OAR 436-120.

(F) If the worker finds employment as a result of the placement services, an employment placement payment of \$500 may be paid to the counselor. If the worker remains employed in that position for at least 30 days, an additional incentive payment of \$500 may be paid to the counselor or agency that provided the placement services.

(G) Employment placement payment and subsequent incentive payment is limited to a maximum of three employment placements.

(H) Placement and incentive payments are limited to one use each per employer.

(b) To request **payment for placement services** provided, a completed and signed [Form 5135](#), "Preferred Worker Program

Placement Payment Request," must be submitted to the division along with a detailed invoice of services provided.

(c) All requests for reimbursement for placement services must be made within one year of the placement assistance agreement end date.

Statutory authority: ORS 656.726(4), 656.622

Statutes implemented: ORS 656.622

Hist.: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0346 Employment Purchases – Employer at Injury Activated

Conditions for use of employment purchases by the employer at injury are:

(1) The employer must submit to the division a completed [Form 2350](#), "Preferred Worker Employment Purchase Agreement," listing items that are required of the worker to perform the job for which the worker is employed; and

(2) The employer may use each employment purchase category once per eligibility period.

Statutory authority: ORS 656.726(4), 656.622

Statutes implemented: ORS 656.622

Hist.: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0347 Employment Purchases – Worker Activated

(1) Conditions for use of employment purchases by a worker are:

(a) Except for moving expenses, placement assistance, and miscellaneous purchases needed to find a job, the worker and employer must submit a completed employment purchase agreement listing items that are required of the worker to obtain or perform the job;

(b) Employment purchases may be used with a nonsubject employer in Oregon; and

(c) The limits for each type of purchase will be restored if there is a subsequent claim closure and the worker is unable to return to regular work.

(2) A preferred worker may request employment purchases as follows:

(a) The worker must contact the division directly for assistance in receiving employment purchases. The worker may make the request before employment, as long as there is a job offer with a start date, but not more than three years after the date of hire; and

(b) [Form 2350](#), "Preferred Worker Employment Purchase Agreement," must be completed and signed by the worker and employer and submitted to the division. Only the worker's signature is required if the request is for moving expenses, placement assistance, or the miscellaneous category.

Statutory authority: ORS 656.726(4), 656.622

Statutes implemented: ORS 656.622

Hist.: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0350 Worksite Modification – General Provisions

(1) Worksite modification defined.

(a) Worksite modification means altering a worksite by purchasing, modifying, or supplementing equipment, or

changing the work process, to enable a worker to work within the restrictions caused by a compensable injury or occupational disease.

(b) For purposes of the Preferred Worker Program, "worksite" means a primary work area that is in Oregon, already constructed, and available for a worker to use to perform the required job duties. The worksite may be the employer's, client's, or worker's premises, property, or equipment used to conduct business under the employer's or client's direction and control. A worksite may include a worker's personal property or vehicle if required to perform the job. If the worksite is mobile, it must be available in Oregon for inspection and modification.

(2) Conditions for use.

Conditions for the use of worksite modification assistance are as follows:

(a) Modifications must allow the worker to perform the job duties within the worker's injury-caused permanent restrictions. In order to determine appropriate worksite modifications, the division worksite modification consultants have discretion to use reports by a medical service provider specific to the worker, specific documented "best practices" described by a medical service provider or authority, and their own professional judgment and experience;

(b) A job analysis that includes the duties and physical demands of the job before and after modification may be required to show how the modification will overcome the worker's restrictions. The job analysis may be submitted to the attending physician for approval before the modification is performed;

(c) Except as provided in OAR 436-110-0351(2) for employer at injury activated modifications, modifications can be used up to a maximum of \$50,000 per eligibility period, with each use limited to \$35,000. If the worker has an exceptional disability, a modification more than \$35,000 may be provided;

(d) Modifications not to exceed \$2,500 may be provided that would reasonably be expected to prevent further injury or exacerbation of the compensable injury or occupational disease, including any disability resulting from the compensable injury or occupational disease. A division worksite modification consultant will determine the appropriateness of this type of modification based upon the consultant's professional judgment and experience, reports by a medical service provider specific to the worker, or specific documented "best practices" described by a medical service provider or authority. Costs of the modifications are included in the calculation of the total worksite modification costs;

(e) Modifications are limited to \$2,500 for on-the-job training under OAR 436-120, "Vocational Assistance to Injured Workers," or other similar on-the-job training program when the trainer is not the employer at injury. A modification will not be approved for any other type of training;

(f) Modifications up to \$2,500 may be provided to protect the items approved in the worksite modification agreement from

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theft or damage from the weather. Insurance policy premiums will not be paid;

(g) When a vehicle is being modified, the vehicle owner must provide proof of ownership and insurance coverage. The worker must have a valid driver license with any applicable classification or endorsement;

(h) Rented or leased vehicles and other equipment will not be modified;

(i) Modifications must be reasonable, practical, and feasible, as determined by the director;

(j) When the director determines the appropriate form of modification and the worker or employer requests a form of modification equally appropriate but with a greater cost, upon director approval, funds equal to the cost of the form of modification identified by the director may be applied toward the cost of the modification desired by the worker or employer;

(k) A modification may include rental of tools, equipment, fixtures, or furnishings to determine the feasibility of a modification. It may also include consultative services necessary to determine the feasibility of a modification, or to recommend or design a worksite modification;

(l) Rental of worksite modification items and consultative services require director approval and are limited to a cost of up to \$5,000 each. The cost for rental of worksite modification items and consultative services does not apply toward the total cost of a worksite modification;

(m) Modification equipment will become the property of the employer, worker, or client on the end date of the worksite modification agreement, or when the worker's employment ends, whichever occurs first. The director will determine ownership of worksite modification equipment before approving an agreement and has the final authority to assign property;

(n) The director may request a physical capacities evaluation, work tolerance screening, or review of a job analysis to quantify the worker's injury-caused permanent restrictions. The cost of temporary lodging, meals, public transportation, and use of a personal vehicle necessary for a worker to participate in one or more of these required activities will be reimbursed at the rate published in [Bulletin 112](#). The cost of the services described in this subsection must be paid by the insurer;

(o) If the property provided for the modification is damaged, in need of repair, or lost, the director will not repair or replace the property;

(p) The employer must not dispose of the property provided for the modification or reassign it to another worker while the worker is employed in work for which the modification is necessary or before the end of the agreement without director and worker approval. Failure to repair or replace the property, or inappropriate disposal or reassignment of the property, may result in sanctions under OAR 436-110-0900; and

(q) The worker must not dispose of the property provided for the modification while employed in work for which the modification is necessary or before the end of the agreement

without director approval. Failure to repair or replace the property, or inappropriate disposal of the property, may result in sanctions under OAR 436-110-0900.

(3) Requests for assistance, payment, and reimbursement.

(a) A worker, employer, or the worker's or employer's representative, may request worksite modification assistance.

(b) A division worksite modification consultant will determine if competitive quotes are required.

(c) The director must create and approve a completed and signed worksite modification agreement before any reimbursement or payment.

(d) Costs of approved worksite modifications will be paid by reimbursement or other instrument of payment approved by the director.

(e) The director will provide payment but will not otherwise assume responsibility for worksite modifications.

(f) The person or entity that purchased the items may request reimbursement by submitting to the division proof of payment for the items purchased. Reimbursement will be made for only those items and costs approved and paid.

(g) All requests for reimbursement must be made within one year of the date the worksite modification agreement ends. No specific form is required.

(h) Reimbursed costs may not be charged by the insurer to the employer as claims costs or by any other means.

Statutory authority: ORS 656.726(4), 656.622

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

Amended 6/13/22 as Admin. Order 22-059, eff. 7/1/22

436-110-0351 Worksite Modification – Employer at Injury Activated

Conditions for use of worksite modifications by the employer at injury are as follows:

(1) The employer at injury may use worksite modification assistance once for a job provided for its injured worker, or a second time if the worker changes to another job with the employer at injury within the timeframes allowed in OAR 436-110-0290(1);

(2) Modifications are limited to a maximum of \$35,000 on the claim that qualified the worker for assistance. A modification of more than \$35,000 may be provided if the worker has an exceptional disability; and

(3) Modifications may be provided for requests received within 180 days from the worker's claim closure date. Additional modifications may be provided under an approved agreement by addendum for requests received within three years from the date the worker started work for the employer in employment for which the worksite modification request was made.

Statutory authority: ORS 656.726(4), 656.622

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0352 Worksite Modification – Worker Activated

Conditions for use of worksite modification assistance by the worker are as follows:

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(1) Modifications may be provided for requests received within three years from the date of hire;

(2) A worker may use worksite modification assistance as often as necessary but only once per employer, with each use is limited to \$35,000; and

(3) A worker can use a second worksite modification with the same employer for a new job if the majority of the job duties have changed.

Statutory authority: ORS 656.726(4), 656.622

Statutes implemented: ORS 656.622

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0850 Audits

(1) Insurers and employers are subject to periodic program and fiscal audits by the director. All reimbursements are subject to subsequent audits, and may be disallowed on any of the grounds set forth in these rules. Disallowed reimbursements may be recovered by the director directly or from future reimbursements by offset. If the director finds upon audit that procedures that led to disallowed reimbursements are still being used, the director may withhold further reimbursements until corrections satisfactory to the director are made.

(2) An insurer or employer must maintain claim records, notices, worker payroll records, reports, receipts, and documentation of payment supporting re-employment assistance costs for which reimbursement has been requested or payment has been made. These records must be maintained for a period of three years after the last reimbursement request or payment.

(3) The director reserves the right to visit the worksite to determine compliance with the agreement under which re-employment assistance has been provided.

Statutory authority: ORS 656.455, 656.622, 656.726(4), 731.475;

Statutes implemented: ORS 656.455, 656.622, 731.475

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-110-0900 Sanctions

(1) Penalties for false statement or report or misrepresentation.

Any person who knowingly makes any false statement or representation to the director or an employee of the director for the purpose of obtaining any benefit or payment from the Preferred Worker Program, or who knowingly misrepresents the amount of a payroll or knowingly submits a false payroll report, is subject to penalties under ORS 656.990.

(2) Reasons for sanction.

Reasons for the director to sanction an individual certified under OAR 436-120, a vocational assistance provider authorized under OAR 436-120, an agency of the State of Oregon, an insurer, an employer, or a preferred worker include, but are not limited to, the following:

(a) Misrepresenting information in order to obtain re-employment assistance. Examples of misrepresentation include:

(A) Changing a job description or job title in order to obtain benefits when there are not corresponding job duty changes; and

(B) Obtaining a worker's signature on an incomplete, incorrect, or blank agreement or reimbursement request;

(b) Making a serious error or omission that resulted in the director approving a Preferred Worker Program agreement issuing a preferred worker card, or reimbursing claim costs in error;

(c) Failing to abide by the terms and conditions of a Preferred Worker Program agreement;

(d) Failing to abide by the provisions of these rules or ORS 656.990;

(e) Failing to return required receipts or invoices;

(f) Submitting false reimbursement requests or job analyses; or

(g) Altering a payment or form, or purchasing unauthorized items.

(3) Possible sanctions.

The director may order one or more of the following sanctions:

(a) Ordering the person being sanctioned to repay the department for re-employment assistance costs incurred, including the department's legal costs;

(b) Prohibiting the person being sanctioned from negotiating or arranging re-employment assistance for such period of time as the director deems appropriate;

(c) Decertifying an individual or vocational assistance provider under the authority of OAR 436-120;

(d) Ordering an employer or worker ineligible for re-employment assistance for a specific period of time; or

(e) Pursuing civil or criminal action against the party.

Statutory authority: ORS 656.622, 656.726(4);

Statutes implemented: ORS 656.622, 656.745, 656.990

Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

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**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 120**

VOCATIONAL ASSISTANCE TO INJURED WORKERS

Effective July 1, 2024

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436-120-0003 Purpose and Applicability of These Rules

(1) Purpose of these rules.

The purpose of the rules in OAR 436-120 is to:

(a) Prescribe uniform standards for determining eligibility, delivery, and payment for vocational services to injured workers;

(b) Prescribe procedures for resolving disputes; and

(c) Establish standards for the certification of counselors and providers.

(2) Applicability of rules.

(a) The rules in OAR 436-120 govern vocational assistance under the workers' compensation law on or after the effective date of these rules.

(b) The director's decisions under OAR 436-120-0008 regarding eligibility will be based on the rules in effect on the date the insurer issued the notice.

(c) 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.

(d) If the director orders future assistance, such assistance must be provided in accordance with the rules in effect at the time assistance is provided.

(e) Under the rules in OAR 436-120, a claim for aggravation or reopening a claim to process a newly accepted condition is considered a new claim for purposes of vocational assistance eligibility and vocational assistance, except as otherwise provided in these rules.

(3) Director's discretion.

(a) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(b) If the worker has returned to work with the employer at injury, the director reserves the right to verify whether the employment is suitable.

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.206, 656.340

Hist: Amended 7/17/18 as Admin. Order 18-059, eff. 8/1/18

Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0005 Definitions

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made a part of these rules. For the purpose of these rules, unless the context requires otherwise:

(1) **"Cost-of-living matrix"** means the chart issued annually by the division in [Bulletin 124](#) that publishes the conversion factors, effective July 1 of each year, used to adjust for changes in the cost-of-living rate from the date of injury to the date of calculation. The conversion factor is based on the annual

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percentage increase or decrease in the average weekly wage, as defined in ORS 656.211.

(2) **"Counselor"** means the vocational assistance counselor certified under these rules to provide vocational assistance to injured workers and activities for determining a worker's eligibility for vocational assistance.

(3) **"Director"** means the director of the Department of Consumer and Business Services, or the director's designee.

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

(5) **"Employer at injury"** means the organization that employed the worker when the worker sustained the injury or occupational disease.

(6) **"Insurer"** means the insurance company or self-insured employer responsible for the workers' compensation claim.

(7) **"Provider"** means the vocational assistance provider that is an insurer or other public or private organization registered under these rules to provide vocational assistance to injured workers and activities for determining a worker's eligibility for vocational assistance.

(8) **"Reasonable cause"** may include, but is not limited to, a medically documented limitation in the worker's activities due to illness or medical condition of the worker or the worker's family, financial hardship, incarceration for less than six months, or circumstances beyond the reasonable control of the worker. "Reasonable cause" for failure to provide information or participate in activities related to vocational assistance will be determined based upon individual circumstances of the case.

(9) **"Reasonable labor market"** for an occupation means it can be said to have reasonable employment opportunities if competitively qualified workers can expect to find equivalent jobs in the occupation within a reasonable period of time. A reasonable period of time, for workers in the majority of occupations, would be the six months that they could collect regular unemployment insurance benefits, if they were entitled to them.

(10) **"Regular employment"** means the employment the worker held at the time of the injury or at the time of the 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 before the aggravation claim. If the basis for potential eligibility is a reopening to process a newly accepted condition, "regular employment" is the employment the worker held at the time of the injury. When the condition arose after claim closure, "regular employment" is determined as if it were an aggravation claim.

(11) **"Substantial handicap to employment"** means the worker, because of the injury or aggravation, lacks the necessary physical capacities, knowledge, skills, and abilities to be employed in suitable employment.

(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 cognitive, psychological, and physical capability to apply the worker's knowledge and skills.

(12)(a) **"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. A reasonable commuting distance is no more than 50 miles one-way modified by other factors including, but not limited to:

(i) Wage of the job;

(ii) The pre-injury commute;

(iii) The worker's physical capacities, if they restrict the worker's ability to sit or drive for 50 miles;

(iv) Commuting practices of other workers who live in the same geographic area; and

(v) The distance from the worker's residence to the nearest cities or towns that offer employment opportunities;

(C) That pays a suitable wage or would average on a year-round basis a suitable wage;

(D) That 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; and

(E) For which a reasonable labor market as described under OAR 436-120-0157 is documented to exist.

(b) **"Suitable employment"** or **"suitable job"** may also be modified or new employment resulting from an employer at injury activated use of the Preferred Worker Program under OAR 436-110, as described in OAR 436-120-0165(1)(c).

(13) **"Suitable wage"** means:

(a) For the purpose of determining eligibility for vocational assistance, a wage at least 80 percent of the adjusted weekly wage; or

(b) For the purpose of providing or ending vocational assistance, a wage as close as possible to 100 percent of the adjusted weekly wage. 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.

(14) **"Training"** means a vocational rehabilitation service provided to a worker who is enrolled and actively engaged in an authorized training plan as documented on [Form 1081](#), "Training Plan."

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

(16) **"Vocational assistance"** means any of the services, goods, allowances, and temporary disability compensation

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under these rules to assist an eligible worker return to work. This does not include activities for determining a worker's eligibility for vocational assistance.

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0008 Administrative Review and Hearings

(1) Administrative review.

(a) A worker wanting review of any vocational eligibility evaluation or vocational assistance matter must request administrative review by the director.

(b) Under ORS 656.340(11) and OAR 436-120-0185 when the worker and insurer are unable to agree on a counselor, the insurer must request administrative review by the director.

(c) Effective vocational assistance is best realized in a nonadversarial environment. The first objective of administrative review is to bring the parties to resolution through alternative dispute resolution procedures, including mediation conferences, whenever possible and appropriate. When a dispute is not resolved through mutual agreement or dismissal, the director will close the record and issue a director's review and order.

(d) The worker's request for review must be submitted to the division no later than the 60th day after the date the worker received written notice of the insurer's action.

(e) Issues raised by the worker where written notice was not provided may be reviewed at the director's discretion.

(f) The worker, insurer, employer at injury, and provider must supply needed information, attend conferences and meetings, and participate in the administrative review process as required by the director.

(A) Upon the director's request, any party to the dispute must provide available information within 14 days of the request.

(B) The insurer must promptly schedule, pay for, and submit to the division any medical or vocational tests, consultations, or reports required by the director.

(C) The worker, insurer, employer at injury, or provider must simultaneously provide copies of material to the other parties to the dispute when submitting material to the division.

(D) Failure to comply with this subsection may result in the director dismissing the administrative review or deciding the issue on the basis of available information when the worker, insurer, provider, or employer at injury fails to comply without reasonable cause.

(g) The director may issue a letter of agreement under section (6) of this rule when the parties resolve a dispute within the scope of OAR 436-120. The director may issue a letter of agreement instead of an administrative order.

(h) The parties have 60 days from the date the director's review and order is issued to request a hearing under OAR 436-001-0019.

(i) The director may on the director's own motion reconsider or withdraw any order that has not become final by operation of law.

(j) A party may request reconsideration of a director's review and order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new material evidence that could not reasonably have been discovered and produced during the review.

(A) The director may grant or deny a request for reconsideration at the director's sole discretion.

(B) A request for reconsideration must be received by the division before the director's review and order becomes final or, if appealed, before the proposed and final order is issued.

(C) The parties may submit new material evidence consistent with this rule and may respond to such evidence submitted by others.

(D) Parties must simultaneously notify all other interested parties of their contentions and provide them with copies of all additional information presented.

(E) A request for reconsideration does not stay the 60-day time period within which the parties may request a hearing.

(2) Attorney fees.

Attorney fees will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 to 436-001-0440.

(3) Hearings before an administrative law judge.

(a) Under ORS 656.340(16) and 656.704(2), any party that disagrees with an order issued under subsection (1)(c) of this rule or a dismissal may request a hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(b) Under ORS 656.704(2), any party that disagrees with an order of dismissal based on lack of jurisdiction or denial of reimbursement for vocational assistance costs may request a hearing as provided in OAR 436-001-0019 within 30 days after the party received the dismissal or written denial.

(c) Under ORS 656.704(2), an insurer sanctioned under OAR 436-120-0900, a provider or counselor sanctioned under ORS 656.340(9) and OAR 436-120-0915, a provider denied registration under ORS 656.340(9)(a) and OAR 436-120-0800, or an individual denied certification under ORS 656.340(9)(a) and OAR 436-120-0810, may request a hearing as provided in OAR 436-001-0019 no later than 60 days after the party received notification of the action.

(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 issued under ORS 656.745 and OAR 436-120-0900 as follows:

(a) The insurer or employer must submit the request for hearing in writing to the division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The party must submit the request to the division within 60 days after the mailing date of the notice of the proposed order or assessment.

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

(d) The Workers' Compensation Board will conduct the hearing under ORS 656.740 and ORS chapter 183.

(5) Director's order.

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 and these rules.

(6) Letter of agreement.

(a) A dispute regarding vocational assistance may be resolved by agreement between the parties to the dispute. The agreement must be in writing and approved by the director.

(b) A letter of agreement will become effective on the 10th day after the date the director issues the letter of agreement, unless the agreement specifies otherwise. Once the agreement is effective, the director may revise the agreement or reinstate administrative review only under one or more of the following conditions:

(A) A party fails to honor the agreement;

(B) The agreement was based on misrepresentation;

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

(D) All parties request revision or reinstatement of the dispute.

(c) A letter of agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney.

Statutory authority: ORS 656.704(2), 656.726(4)
Statutes implemented: ORS 656.704, 656.340, 656.447, 656.740, 656.745
Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17
Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

**436-120-0009 Submitting Documents or Information,
Calculating Time, Availability of Forms**

(1) Submitting documents or information, calculating time.

(a) Documents or information required under these rules to be submitted to the division may be:

(A) Mailed to the following address:

Workers' Compensation Division
Employment Services Team
350 Winter Street NE
PO Box 14480
Salem, OR 97309-0405;

(B) Physically delivered to the division's Salem office;

(C) Faxed; or

(D) Submitted by any other method authorized by the director.

(b) Timeliness of any document or information required by these rules to be submitted to the division is determined as follows:

(A) If a document is mailed, it will be considered submitted on the date it is postmarked.

(B) If a document is delivered, it must be delivered during regular business hours and marked by the division as received to be considered submitted on that date.

(C) If a document is faxed, it must be received by 11:59 p.m. Pacific Time to be considered submitted on that date. Requests submitted by fax are considered submitted as of the date printed on the banner automatically produced by the transmitting fax machine.

(D) If a document is submitted electronically, it must be received by 11:59 p.m. Pacific Time to be considered submitted on that date. The date and time of receipt for electronic submissions is determined under ORS 84.043.

(c) Time periods under these rules are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

(2) Availability of forms. The forms and bulletins referenced in these rules are available on the division's website at wcd.oregon.gov.

Statutory authority: ORS 656.340(9), 656.726(4)
Statutes implemented: ORS 656.340
Hist: Adopted 6/7/24 as WCD Admin. Order 24-054, eff. 7/1/24
See also the *Index to Rule History*:
https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0012 General Requirements for Notices and Warnings

(1) Insurer or provider may issue.

The insurer is responsible for mailing all notices and warnings required by these rules but may delegate that responsibility to the provider that is providing vocational assistance to the worker.

(2) Required content.

All notices and warnings to the worker issued under these rules must:

(a) Use the applicable heading. If a notice is used for more than one purpose, it must include all the headings that apply;

(b) Be in writing, signed, and dated;

(c) State the basis for the decision;

(d) Include the effective date of each action in the heading;

(e) Cite the relevant rules;

(f) Include the telephone number of the Ombuds Office for Oregon Workers: 800-927-1271; and

(g) Include the worker's appeal rights. All notices and warnings except those notifying a worker of entitlement to training or deferral of vocational assistance eligibility must contain the worker's appeal rights:

(A) In bold type, as follows:

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"If you disagree with this decision, you should contact [insert the person's name and the insurer name] 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: Employment Services Team, Workers' Compensation Division, P.O. Box 14480, Salem, Oregon 97309-0405; 1-800-452-0288."

(B) Effective no later than Oct. 1, 2024, the text in (g)(A) of this section must be replaced with the following language in bold and formatted as follows:

If you disagree with this decision, you should contact [Claims examiner's name and the insurer name] within five days of receiving this letter to discuss your concerns.

If you are still dissatisfied:

- Contact the Workers' Compensation Division within 60 days of receiving this letter. After 60 days you will lose your right to appeal this decision.

- A consultant with the division can talk with you about the disagreement and review your appeal, if necessary.

- To contact the division:

**Workers' Compensation Division
Employment Services Team
350 Winter Street NE
PO Box 14480
Salem OR 97309-0405
800-452-0288 (toll-free)**

(3) Mailing and copies.

All notices and warnings must:

(a) Be mailed to the worker's last known address by both regular and certified mail; and

(b) Be copied to the division and worker's attorney, if any, at the same time the notice or warning is mailed to the worker.

(4) Effective date.

A notice is not effective until it is sent to all required parties including the worker's attorney.

(5) Requirements for warning letters.

(a) A warning letter can be issued at any time during the vocational eligibility evaluation or vocational assistance process.

(b) Warning letters do not require specific language in the headings but must include a heading clearly indicating the purpose of the warning.

(c) A warning letter must state what the worker must do, and by when, to avoid ineligibility or the ending of eligibility or training.

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended 12/19/22 as Admin. Order 22-070, eff. 1/1/24

Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0115 Vocational Eligibility Evaluation

(1) Purpose of eligibility evaluation.

An eligibility evaluation is done to determine whether the worker is or is not eligible for vocational assistance.

(2) When an eligibility evaluation is not required.

An eligibility evaluation is not required if:

(a) The worker's claim is reopened under Own Motion under ORS 656.278;

(b) The worker is receiving permanent total disability benefits; or

(c) The worker is deceased.

(3) When an eligibility evaluation is required.

Except as provided in OAR 436-120-0117, the insurer is required to begin an eligibility evaluation for workers with accepted disabling claims within five days of any of the following conditions:

(a) The insurer receives information such as medical or investigative reports that indicate, before the worker is medically stationary, the worker is likely eligible for vocational assistance;

(b) The worker is medically stationary, is not currently receiving vocational assistance, and:

(A) Has not returned to or been released to regular employment; or

(B) Has not returned to other suitable employment with the employer at the time of injury or aggravation; or

(c) Eligibility was previously determined under the current opening of the claim and the insurer has accepted a new condition.

(4) Services may be provided at any time.

Nothing in these rules prevents an insurer from finding a worker eligible and providing vocational assistance at any time.

(5) Worker request for vocational assistance.

If the insurer receives a request for vocational assistance from the worker and the insurer is not required to do an eligibility evaluation, the insurer may not deny eligibility for assistance, but must notify the worker in writing within 14 days of the request of:

(a) The reasons an eligibility evaluation is not required;

(b) The circumstances that require an eligibility evaluation; and

(c) Instructions to contact the division with questions about vocational assistance eligibility requirements and procedures.

(6) The eligibility evaluation process.

(a) The eligibility evaluation must be done by a counselor.

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(b) At the insurer's request, the worker must provide vocationally relevant information needed to determine eligibility within a reasonable time set by the insurer.

(c) The insurer must provide the counselor with all relevant vocational and medical information.

(d) The eligibility evaluation process, including notifying the worker of the results under section (9) of this rule, must be completed within 30 days of when the process began under section (3) of this rule, unless extended under section (7) of this rule.

(e) Either the insurer or the counselor may notify the worker of the results of the eligibility evaluation under section (9) of this rule.

(7) Extension of time.

(a) The counselor may extend the time frame in section (6) of this rule for completing the eligibility evaluation if the counselor is unable to obtain needed information from the worker, employer, or medical provider.

(b) An extension of time may be for no more than 30 days.

(c) The counselor must notify the worker of the extension under section (8) of this rule, and submit a copy of the letter to the division.

(8) Notice of extension of time.

The letter informing the worker that the time frame for completing the eligibility evaluation process has been extended must:

(a) Clearly indicate the purpose of the letter;

(b) Explain the reason for the extension of time;

(c) Explain what information is necessary to complete the eligibility evaluation process;

(d) State when the eligibility evaluation process is expected to be completed;

(e) Be mailed to the worker within five days of the date the counselor determines an extension is needed under subsection (7)(a) of this rule; and

(f) Include the following language:

(A) In bold text:

"If you have questions about the vocational assistance process, contact [use appropriate reference to the insurer]. If you still have questions contact the Workers' Compensation Division's toll free number 1-800-452-0288."

(B) Effective no later than Oct. 1, 2024, the text under (f)(A) of this section must be replaced with the following language in bold and formatted as follows:

If you have questions about vocational assistance, contact:

[Insurer name]

[Insurer contact person]

[Insurer address]

[Insurer phone number]

If you still have questions, call the Workers' Compensation Division at 800-452-0288 (toll-free).

(9) Results of the eligibility evaluation.

The results of the eligibility evaluation must be mailed to the worker following the requirements for the appropriate notice under subsection (a) or (b) of this section.

(a) The NOTICE OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE must:

(A) Include the worker's responsibilities, as specified in OAR 436-120-0197(2) and 436-120-0520(1);

(B) Include the following statement:

(i) In bold text:

"You have the right to request a return-to-work plan conference if the insurer does not approve a return-to-work plan within 90 days of determining you are entitled to a training plan, or within 45 days of determining you are entitled to a direct employment plan. The purpose of the conference will be to identify and remove all obstacles to return-to-work plan completion and approval. The insurer, the worker, the counselor, and any other parties involved in the return-to-work process must attend the conference. The insurer or the worker may request a conference with the division if other delays in the vocational assistance process occur. Your request for this conference should be directed to the Employment Services Team of the Workers' Compensation Division. The address and telephone number of the division are: Employment Services Team, Workers' Compensation Division, P.O. Box 14480, Salem, Oregon 97309-0405; 1-800-452-0288."

(ii) Effective no later than Oct. 1, 2024, the text in (B)(i) of this subsection must be replaced with the following language in bold and formatted as follows:

You have the right to request a return-to-work plan conference if the insurer does not approve a return-to-work plan:

- Within 90 days of determining you are entitled to a training plan, or
- Within 45 days of determining you are entitled to a direct employment plan.

Conference purpose: Identify and remove obstacles to return-to-work plan completion and approval.

Conference attendance: The insurer, the worker, the counselor, and others involved in the return-to-work process must attend.

Other conferences: The insurer or the worker may request a conference with the Workers' Compensation Division about other delays in vocational assistance.

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To request a conference, write or call:

**Workers' Compensation Division
Employment Services Team
PO Box 14480
Salem, OR 97309-0405
800-452-0288 (toll-free)**

(C) Explain that the worker and the insurer must agree on the selection of a counselor, and:

(i) Provide instructions for the worker to access the list of counselors on the division's website

(wcd.oregon.gov/rtw/Pages/voc-assistance.aspx);

(ii) Include a phone number for the worker to call to request a paper copy of the list; and

(iii) Include the following language:

(I) In bold text:

"If you have questions about the vocational counselor selection process, contact [use appropriate reference to the insurer]. If you still have questions, call the Workers' Compensation Division at 1-800-452-0288.";

(II) Effective no later than Oct. 1, 2024, the text in (iii)(I) of this paragraph must be replaced with the following language in bold and formatted as follows:

If you have questions about the process for selecting a vocational counselor, contact:

[Insurer name]

[Insurer contact person]

[Insurer address]

[Insurer phone number]

If you still have questions, call the Workers' Compensation Division at 800-452-0288 (toll-free).

(D) Include information about the Preferred Worker Program;

(E) Explain what the worker can do if the worker disagrees with something the insurer does;

(F) Explain direct employment services and state the worker is not entitled to training, if the worker is entitled to direct employment services but not training; and

(G) Include the category of vocational assistance and the reason for the selection as described in OAR 436-120-0177(2).

(b) The NOTICE OF INELIGIBILITY FOR VOCATIONAL ASSISTANCE must include:

(A) Information about services that may be available at no cost from the Oregon Employment Department or the Office of Vocational Rehabilitation Services;

(B) A brief description of the Preferred Worker Program benefits and contact information. The information can be part of the notice or a separate document attached to the notice; and

(C) A list of suitable occupations the worker can perform without being retrained, if the notice is based on a finding that the worker does not have a substantial handicap to employment.

(10) Multiple claims.

Vocational assistance may only be provided for one claim at a time. If the worker is eligible for vocational assistance under two or more claims, the claim for the injury with the most severe vocational impact is the claim that gave rise to the need for vocational assistance. The parties may agree to provide services for more than one claim at a time, and extend time and fee limits beyond those allowable in these rules.

Statutory authority: ORS 656.340, ORS 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

Amended 6/13/22 as Admin. Order 22-060, eff. 7/1/22

Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0117 Deferral of Eligibility Evaluation

(1) Deferral of eligibility evaluation.

The eligibility evaluation may be deferred when all of the following circumstances exist:

(a) The employer at injury has activated Preferred Worker Program benefits under OAR 436-110;

(b) The employer has made a written job offer to the worker that includes the following information:

(A) The start date;

(B) Wage and hours;

(C) Job site location;

(D) Description of job duties that includes physical requirements; and

(E) A statement that the job does not begin until any modifications are in place;

(c) The worker has agreed in writing to accept the new or modified job; and

(d) If the new or modified job needs worksite modifications to enable the worker to perform the job duties within the worker's injury-caused limitations:

(A) The modifications are in progress but not yet complete and the worker is working in a temporary modified position with the employer at injury that accommodates the worker's restrictions; or

(B) The worksite modifications are in place and the worker is working in and receiving payment for the new or modified job.

(2) Notice of deferral.

(a) When the eligibility evaluation process is deferred under this rule, the insurer must mail the worker a NOTICE OF DEFERRAL OF VOCATIONAL ASSISTANCE ELIGIBILITY EVALUATION.

(b) The notice must be mailed within five days of the date the conditions in section (1) exist.

(c) The notice must:

(A) Inform the worker that the eligibility evaluation has been deferred because the employer at injury has activated preferred worker benefits;

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(B) Inform the worker that, if the job with the employer at injury does not begin on the date stated in the job offer letter, the worker can ask the insurer to resume the eligibility evaluation process; and

(C) Include the following language:

(i) In bold text:

"If you have questions about the deferral of the process for determining your eligibility for vocational assistance, contact [use appropriate reference to the insurer]. If you still have questions contact the Workers' Compensation Division's toll free number 1-800-452-0288."

(ii) Effective no later than Oct. 1, 2024, the text in (C)(i) of this subsection must be replaced with the following language in bold and formatted as follows:

If you have questions about this deferral, contact:

[Insurer name]

[Insurer contact person]

[Insurer address]

[Insurer phone number]

If you still have questions, call the Workers' Compensation Division at 800-452-0288 (toll-free).

(3) Resumption of eligibility evaluation process.

If the eligibility evaluation has been deferred under this rule, the insurer must resume the process within 14 days of:

(a) A determination that preferred worker benefits will not be provided;

(b) Termination of the Preferred Worker Program agreement;

(c) Termination of the job offer; or

(d) The temporary modified position ends and the worksite modifications are still in progress.

Statutory authority: ORS 656.340, ORS 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended and renumbered 11/28/16 from 436-120-0155, as Admin. Order 16-058, eff. 1/1/17

Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0145 Vocational Assistance Eligibility

(1) A worker whose permanent total disability benefits have been terminated by a final order is eligible for vocational assistance.

(2) A worker is eligible for vocational assistance if all of the following conditions are met:

(a) The worker is available in Oregon or within commuting distance of Oregon, unless:

(A) The worker states in writing that within 30 days of being determined eligible for vocational assistance the worker will move back to Oregon, or within commuting distance of Oregon, at the worker's expense;

(B) The worker did not work and live in Oregon at the time of the injury;

(C) The worker needs to live outside of Oregon due to financial hardship, family circumstances over which the worker has no control, or other similar situation; or

(D) The training program or supporting labor market for a specific vocational goal is only available outside of Oregon;

(b) 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 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;

(c) The worker was not employed in suitable employment for at least 60 days after the injury or aggravation;

(d) The worker did not refuse or fail to make a reasonable effort in available light-duty work intended to result in suitable employment. Before finding the worker ineligible, the insurer must document the existence of one or more suitable jobs that would be available for the worker after completion of the light-duty work. If the employer at injury offers such employment to a worker who is not medically stationary, the offer must be made in accordance with OAR 436-060-0030;

(e) The worker is available for vocational assistance. If the worker is not available, the insurer must determine if the reasons are for reasonable or unreasonable cause before finding the worker ineligible. If the reason was for incarceration, this reason must be stated in the notice to the worker. Declining vocational assistance to accept modified or new employment that results from an employer at injury activated use of the Preferred Worker Program, under OAR 436-110, is reasonable cause; and

(f) The worker did not refuse or otherwise relinquish their rights to vocational assistance in writing.

(3) Individuals covered under ORS 656.033, 656.046, 656.135, or 656.138 (work experience program participants, apprentices, trainees), are eligible for vocational assistance if they otherwise meet the eligibility requirements in section (2) of this rule. For purposes of vocational assistance:

(a) The employer at injury is the district, college, or school conducting the program or project in which the individual was injured;

(b) Regular employment is the job for which the individual was being trained at the time of the injury; and

(c) The assumed wage upon which premium was based, but in no event less than minimum wage, should be used to determine suitable wage under OAR 436-120-0147.

(4) The worker must participate in the vocational assistance process and must provide relevant information. If the worker does not participate, or fails to provide relevant information, the insurer must issue a written warning before finding the worker ineligible under this rule.

(5) The worker must not misrepresent a matter material to evaluating eligibility.

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Statutory authority: ORS 656.340, ORS 656.726(4)
Statutes implemented: ORS 656.206, 656.340
Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17
Amended 6/13/22 as Admin. Order 22-060, eff. 7/1/22
Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0147 Establishing the Adjusted Weekly Wage

(1) General provisions.

(a) To determine a suitable wage the insurer must first establish the adjusted weekly wage as described in this rule.

(b) The insurer must calculate the adjusted weekly wage whenever determining or redetermining a worker's eligibility for vocational assistance.

(c) All figures used in determining a weekly wage by this method must 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 Oregon Employment Department.

(d) If the insurer is unable to obtain complete information to calculate the weekly wage under section (3) of this rule, but the worker does provide verifiable documentation to establish wages at the time of injury, the insurer must make a reasonable calculation of the worker's weekly wage based on the verifiable documentation available.

(2) Definitions.

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) **"Earned income"** means gross wages, salary, tips, commissions, incentive pay, bonuses, and the reasonable value of other consideration (such as housing, utilities, and food) received from all employers for services performed from all jobs held at the time of injury or aggravation. 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, employer contributions to pension plans, or reimbursement of the worker's employment expenses such as mileage or equipment rental.

(d) **"Job at aggravation"** means the job or jobs the worker held on the date of the aggravation claim or, for a worker not employed at the time of aggravation, the last job or concurrent jobs held before the aggravation. The job does not need to be subject employment. Volunteer work is not a job for purposes of this subsection unless the worker is a subject worker under ORS 656.031 or 656.039, and the worker originally sustained the compensable injury at the volunteer job.

(e) **"Job at injury"** is the job on which the worker originally sustained the compensable injury. For an occupational disease, the job at injury is the job the worker held at the time there is

medical verification that the worker is unable to work because of the disability caused by the occupational disease. Volunteer work is not a job for purposes of this subsection unless the worker is a subject worker under ORS 656.031 or 656.039, and the worker originally sustained the compensable injury at the volunteer job.

(f) **"Permanent employment"** is a job with no projected end date or a job that had no projected end date at the time of hire. Permanent employment may be year-round or seasonal.

(g) **"Permanent, year-round employment"** is permanent employment in which the worker worked or was scheduled or projected to work in 48 or more calendar weeks a year. Paid leave is 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) **"Temporary disability"** means wage loss replacement for the job at injury.

(i) **"Time of injury"** means, in the case of an injury, the date of injury or, in the case of an occupational disease, the time there is medical verification that the worker is unable to work because of the disability caused by the occupational disease.

(j) **"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.

(3) Determining weekly wage.

The insurer must determine the nature of the job at injury and any other paid jobs held at the time of injury, or the job or jobs at aggravation, and this must include contacting the employer at injury to verify the worker's employment status.

(a) When the job at injury or any other paid jobs held at the time of injury, or the job at aggravation was **seasonal or temporary**, calculate the worker's weekly wage as follows, then convert to the adjusted weekly wage as described in section (4) of this rule:

(A) When the worker's regular employment is the **job at injury** and the worker did not hold more than one job at the time of injury, and did not receive unemployment insurance benefits during the 52 weeks before the injury, use the same wage upon which temporary disability was based.

(B) When the worker's regular employment is the **job at aggravation** and the worker did not hold more than one job at the time of aggravation, and did not receive unemployment insurance benefits during the 52 weeks before the aggravation, use the same methods used to calculate temporary disability as described under OAR 436-060-0025 that was in effect on the date of injury.

(C) When the worker held **more than one job** at the time of injury or aggravation, and did not receive unemployment insurance payments during the 52 weeks before the date of the injury or aggravation, divide the worker's earned income by the number of weeks the worker worked in those jobs during the 52 weeks before the date of injury or aggravation.

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(D) When the worker held **one or more jobs** at the time of injury or aggravation, and received unemployment insurance payments during the 52 weeks before the date of the injury or aggravation, combine the earned income with the unemployment insurance payments and divide the total by the number of weeks the worker worked in those jobs and received unemployment insurance payments during the 52 weeks before the date of the injury or aggravation.

(b) When subsection (3)(a) of this rule does not apply, calculate the worker's weekly wage as follows, then convert to the adjusted weekly wage as described in section (4) of this rule:

(A) When the worker's regular employment is the **job at injury** and the worker **did not hold more than one job** at the time of injury, use the same wage upon which temporary disability was based.

(B) When the worker's regular employment is the **job at injury** and the worker **held more than one job** at the time of injury, use the same methods used to calculate temporary disability as described under OAR 436-060-0025 that was in effect on the date of injury. The job does not need to be subject employment.

(C) When the worker's regular employment is the **job at aggravation**, use the same methods used to calculate temporary disability as described under OAR 436-060-0025 that was in effect on the date of injury.

(c) When a volunteer job is the job at injury or job at aggravation, the wage for the volunteer job is based on the assumed wage used to determine the employer's premium.

(4) Adjusted weekly wage.

After arriving at the worker's weekly wage under section (3) of this rule, establish the adjusted weekly wage by determining the percentage increase or decrease from the date of injury or aggravation, or last day worked before aggravation, to the date of calculation, as follows:

(a) Contact the employer at injury regarding any cost-of-living or collective bargaining adjustments for workers performing the same job. Adjust the total of all of the weekly wages from section (3) of this rule by any percentage increase or decrease;

(b) If the employer at injury 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 total of all of the weekly wages from section (3) of this rule by the percentage increase or decrease;

(c) If the employer at injury is no longer in business or does not currently employ workers in the same job category, adjust the total of all of the weekly wages from section (3) of this rule by the appropriate factor from the cost-of-living matrix in [Bulletin 124](#);

(d) If the worker's regular employment was the employment the worker held at the time of aggravation, adjust the total of all of the weekly wages from section (3) of this rule by the appropriate factor from the cost-of-living matrix in [Bulletin 124](#).

Statutory authority: ORS 656.340(9), ORS 656.726(4)
Statutes implemented: ORS 656.340(5) and (6)
Hist: Amended 2/22/18 as Admin. Order 18-051, eff. 2/23/18
Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0157 Determining Substantial Handicap to Employment

(1) A counselor must do a substantial handicap evaluation as part of the eligibility evaluation when applicable.

(2) To complete the substantial handicap evaluation the counselor must submit a report documenting the following information about the worker:

(a) Relevant work history for at least the preceding five years;

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

(c) Adjusted weekly wage and suitable wage;

(d) Permanent limitations due to the injury;

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

(f) A list of physically suitable jobs for which the worker has the knowledge, skills, and abilities, that pay a suitable wage, and for which a reasonable labor market is documented to exist as described in subsection (g);

(g) An analysis of the worker's labor market using standard labor market reference materials, including but not limited to information provided by the Employment Department's Oregon Labor Market Information System (OLMIS) and Oregon Wage Information (OWI) (available on the Oregon Employment Department's website at www.qualityinfo.org/). When using OWI data, the presumed standard will be the 10th percentile unless there is sufficient evidence that a higher or lower wage is more appropriate; and

(h) Consideration of the vocational impact of any limitations that existed before the injury.

(3) When determining the worker's eligibility for vocational assistance, the insurer may consider any knowledge, skills, and abilities the worker gained after the date of injury or aggravation that resulted from training provided by the employer; however, the insurer may not include any knowledge, skills, or abilities the worker gained at their own expense after the date of injury or aggravation.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.340(5) and (6)
Hist: Amended 6/13/22 as Admin. Order 22-060, eff. 7/1/22

436-120-0165 End of Eligibility for Vocational Assistance

(1) Reasons for ending eligibility.

A worker's eligibility for vocational assistance ends when any of the following conditions apply:

(a) Based on **new information** that did not exist or that could not have been obtained with reasonable effort at the time the insurer determined eligibility, the worker no longer meets the eligibility requirements;

(b) The worker has been employed in **suitable employment** for at least 60 days after the date of injury or date of aggravation;

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(c) The worker has been employed in suitable employment that is modified or new employment resulting from an **employer-at-injury activated use of the Preferred Worker Program** under OAR 436-110 and:

(A) If there is no worksite modification, premium exemption has been effective for 12 months;

(B) If there is a worksite modification, 12 months have passed since the director determined it to be complete; or

(C) During the 12-month period in paragraph (A) or (B), the worker is terminated for cause or voluntarily resigns for a reason unrelated to the work injury;

(d) The worker, before beginning an authorized return-to-work plan, **refused an offer of suitable employment**. If the employer-at-injury offers employment to a worker who is not medically stationary, the offer must be made in accordance with OAR 436-060-0030;

(e) The worker, before beginning an authorized return-to-work plan, **left suitable employment** after the injury or aggravation for a reason unrelated to the limitations caused by the injury;

(f) The worker, before beginning an authorized return-to-work plan, **refused or failed to make a reasonable effort in available light-duty work** intended to result in suitable employment. Before ending eligibility, the insurer must document the existence of one or more suitable jobs that would be available for the worker after completion of the light-duty work. If the employer at injury offers such employment to a worker who is not medically stationary, the offer must be made in accordance with OAR 436-060-0030;

(g) The worker, after completing an authorized training plan, **refused an offer of suitable employment**;

(h) The worker **declined or became unavailable** for vocational assistance.

(A) The insurer must determine if the reasons are for reasonable or unreasonable cause before ending the worker's eligibility.

(B) If the reason was for incarceration, this reason must be stated in the notice to the worker.

(C) Declining vocational assistance to accept modified or new employment that results from an employer-at-injury activated use of the Preferred Worker Program, under OAR 436-110, is reasonable cause;

(i) The worker **refused a suitable training site** after the counselor and worker have agreed in writing upon a return-to-work goal;

(j) The worker **failed after written warning to participate in the development or implementation** of a return-to-work plan. No written warning is required if the worker fails to attend two consecutive training days and fails, without reasonable cause, to notify the counselor or the insurer by the close of the next business day;

(k) The worker's lack of suitable employment **cannot be resolved by providing vocational assistance**. This includes circumstances in which the worker cannot benefit from, or

participate in, vocational assistance because of medical conditions unrelated to the injury;

(l) The worker **misrepresented information** relevant to providing vocational assistance;

(m) The worker **refused after written warning to return property** provided by the insurer or reimburse the insurer as required. No vocational assistance will be provided under subsequent openings of the claim until the worker returns the property or reimburses the funds;

(n) The worker **misused funds** provided for the purchase of property or services. No vocational assistance will be provided under subsequent openings of the claim until the worker reimburses the insurer for the misused funds;

(o) After written warning the worker continues to **harass** any participant to the vocational process. This subsection does not apply if such behavior is the result of a documented medical or mental condition;

(p) The worker entered into a **claim disposition agreement** and disposed of vocational rights. The parties may agree in writing to suspend vocational assistance pending approval of the agreement by the Workers' Compensation Board. The insurer must end eligibility when the Workers' Compensation Board approves the claim disposition agreement that disposes of vocational assistance rights. No notice regarding the end of eligibility is required; or

(q) The worker received **maximum direct employment services** or **maximum limited training services** and is not entitled to other categories of vocational assistance.

(2) Notice of end of eligibility.

When an insurer ends a worker's eligibility for vocational assistance, the insurer must mail to the worker a NOTICE OF END OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE within five days of the end of eligibility date. The notice must include:

(a) The date when eligibility ended. The effective date is the worker's last date of eligibility; and

(b) The reason the worker's eligibility for vocational assistance is ending. However, notice is not required if the insurer is ending the worker's eligibility because the worker has given up their vocational assistance rights through a claim disposition agreement.

(3) Report to director.

When an insurer ends a worker's eligibility for vocational assistance, the insurer must submit to the division, within 30 days after the date eligibility ends, [Form 2800](#), "Vocational Closure Report." The report must include:

(a) The effective date for the end of eligibility;

(b) The reason for the end of eligibility; and

(c) Return-to-work and provider information.

Statutory authority: ORS 656.340, ORS 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended 6/13/22 as Admin. Order 22-060, eff. 7/1/22

Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

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436-120-0175 Redetermining Eligibility for Vocational Assistance

(1) If the worker was previously determined ineligible for vocational assistance or the worker's eligibility for vocational assistance ended, the insurer must redetermine eligibility within 30 days of notification of a change of any of these circumstances:

(a) The worker, for reasonable cause, was unavailable for vocational assistance and is now available;

(b) The worker's lack of suitable employment could not be resolved by providing vocational assistance. The insurer may require the worker to provide evidence that circumstances have changed;

(c) The worker declined vocational assistance to accept modified or new employment that resulted from an employer at injury activated use of preferred worker benefits under OAR 436-110. If the job was not suitable, the worker must request redetermination within 30 days of termination of the employment for which preferred worker benefits were provided;

(d) The worker was not available for vocational assistance in Oregon or within commuting distance of Oregon. The worker must request redetermination within six months of receiving the insurer's notice that the worker was not eligible for this reason;

(e) Before claim closure, the worker's limitations due to the injury became more restrictive;

(f) Before claim closure, the insurer accepts a new condition that was not considered in the original determination of the worker's eligibility; or

(g) The worker's average weekly wage is redetermined and increased.

(2) The insurer must redetermine eligibility when the insurer determined the worker ineligible or ended eligibility solely on the basis that the worker was not authorized to work in the United States:

(a) Within 30 days of July 1, 2024, if the worker received the insurer's notice of ineligibility or end of eligibility on or after Dec. 30, 2023; or

(b) Within 30 days of receipt of the worker's second request for redetermination if the worker:

(A) Received the insurer's notice of ineligibility or end of eligibility before Dec. 30, 2023;

(B) Requested redetermination within six months of the date they received the insurer's notice of ineligibility or end of eligibility;

(C) Submitted evidence to the insurer within six months of the date the worker received the insurer's notice of ineligibility or end of eligibility that the worker had applied for authorization to work in the United States and was awaiting a decision by the U.S. Citizenship and Immigration Services (USCIS); and

(D) Submitted a second request for redetermination on or after July 1, 2024.

(3) A worker who requests redetermination under (2)(b) of this rule is not required to be authorized to work in the United States. However, the worker may not request redetermination after the 30th day from receipt of any decision by USCIS.

Statutory authority: ORS 656.340, ORS 656.726(4)
Statutes implemented: ORS 656.340
Hist: Amended 6/13/22 as Admin. Order 22-060, eff. 7/1/22
Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0177 Selection of Category of Vocational Assistance

(1) The insurer must select one of the following categories of vocational assistance before referring a worker to a counselor:

(a) **Direct employment services**, if the worker has the necessary transferable skills to obtain suitable new employment.

(b) **Training**, if the worker needs training in order to return to employment that pays a wage significantly closer to 100 percent of the adjusted weekly wage. "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.

(c) **Limited training**, if the worker is not authorized to work in the United States and needs training in order to return to employment that pays a wage significantly closer to 100 percent of the adjusted weekly wage. "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.

(2) The insurer must notify the worker of the category selection and the reason for the selection in the NOTICE OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE issued under OAR 436-120-0115(9).

(3) The insurer must reconsider the category of vocational assistance within 30 days of the insurer's knowledge of a change in circumstances including, but not limited to:

(a) A change in the worker's permanent limitations;

(b) A change in the labor market; or

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

(4) The insurer must notify the worker within five days if the reconsideration under section (3) results in a change in the vocational assistance category.

Statutory authority: ORS 656.340(9), 656.726(4)
Statutes implemented: ORS 656.340(7)
Hist: Amended and renumbered 11/28/16 from 436-120-0400, as Admin. Order 16-058, eff. 1/1/17
Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0185 Choosing a Counselor

(1) **Choosing a counselor.**

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(a) The insurer and worker must agree on a counselor within 14 days of the worker being determined eligible for vocational assistance.

(b) When the parties agree on a counselor, the insurer must mail the worker a NOTICE OF SELECTION OF VOCATIONAL COUNSELOR.

(c) If the parties do not agree on a counselor, the insurer must notify the division within five days, and the director will select a counselor.

(2) Changing counselors.

(a) If the worker or insurer requests a change in counselor, the insurer and worker must agree on a new counselor within 14 days of the request.

(b) If the parties do not agree on a new counselor, the insurer must refer the matter to the division within five days.

(c) Any time there is a change in counselor, the insurer must mail the worker a NOTICE OF CHANGE OF VOCATIONAL COUNSELOR.

(3) Providing documents to selected counselor. The insurer must provide the vocational counselor selected under (1) or (2) of this rule all relevant vocational and medical information within 14 days of mailing the notice under (1)(b) or (2)(c) of this rule.

Statutory authority: ORS 656.340, ORS 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0187 Optional Services

(1) Optional services are services provided to:

(a) A worker who is not eligible for vocational assistance; or

(b) A worker who is eligible for vocational assistance, in excess of the services described in these rules.

(2) Optional services are provided at the discretion of the insurer.

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

Statutory authority: ORS 656.340, 656.704, 656.726

Statutes implemented: ORS 656

Hist: Amended and renumbered 11/28/16 from 436-120-0455, as Admin. Order 16-058, eff. 1/1/17

436-120-0197 Direct Employment

(1) Direct employment services, generally.

(a) Direct employment services may include, but are not limited to:

(A) Employment counseling;

(B) Job search skills instruction, which teaches 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 obtaining suitable new employment;

(C) Job development with related return-to-work activities, which helps the worker contact appropriate prospective employers; and

(D) Job analysis.

(b) If the insurer determines the worker is entitled to direct employment services, the insurer must provide the worker with at least four months of direct employment services.

(c) A direct employment plan must include a description of the worker's transferable skills that 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 adjusted weekly wage at the time of injury.

(d) Direct employment services must be provided by a counselor.

(e) Direct employment services must begin on the date the insurer approves a direct employment plan, or on the completion date of an authorized training plan.

(f) If the insurer does not approve a direct employment plan within 45 days of determining the worker entitled to a direct employment plan, the insurer must contact the division within five days to schedule a conference.

(A) The purpose of the conference will be to identify and remove all obstacles to plan completion and approval.

(B) The insurer, the worker, the counselor, and any other parties involved in the process must attend the conference.

(C) The conference may be postponed for a period of time agreed on by the parties.

(D) The insurer or the worker may request a conference if other delays in the process occur.

(g) The insurer must provide return-to-work follow-up for at least 60 days after the worker becomes employed to ensure the work is suitable and to provide any necessary assistance that enables the worker to continue the employment.

(2) Responsibilities in direct employment plan.

(a) The worker is responsible for the following in a direct employment plan:

(A) Maintain regular contact with the counselor;

(B) Fully participate in plan services;

(C) Follow up on all job leads in a timely manner;

(D) Be an active participant in the job search;

(E) Accept suitable employment if it is offered and notify the counselor immediately;

(F) Promptly inform the counselor of any problems that might affect participation in the plan; and

(G) Meet any responsibilities agreed to in the plan.

(b) The counselor is responsible for the following in a direct employment plan:

(A) Provide instruction on job-search skills, as necessary;

(B) Provide job development, as necessary;

(C) Provide timely, accurate progress reports to the insurer; and

(D) Meet any responsibilities agreed to in the plan.

(3) Plan amendments.

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(a) If the vocational goal is later changed, the insurer must amend the direct employment plan. All amendments to the plan must be initialed by the insurer, counselor, and worker.

(b) If the insurer amends a proposed plan, the insurer must indicate what the changes are and why they are necessary.

(4) Reporting to the director.

The direct employment plan and any amendments must be submitted to the division within five days of plan approval using [Form 1083](#), "Direct Employment Plan."

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340(7)

Hist: Amended and renumbered 11/28/16 from 436-120-0430, as Admin. Order 16-058, eff. 1/1/17

436-120-0410 Determining a Vocational Goal

A counselor must determine a suitable vocational goal for the worker using one or more of the following:

(1) Vocational testing.

Vocational testing must be administered by an individual certified to administer the test.

(2) Job analysis.

A job analysis is a detailed description of the physical and other demands of a job based on direct observation of the job.

(3) On-the-job evaluation.

An on-the-job evaluation must evaluate a worker's work traits, aptitudes, limitations, potentials, and habits in an actual job environment.

(a) The counselor must perform a job analysis to determine if the job is within the worker's capacities. The insurer must submit the job analysis to the attending physician if there is any question about the appropriateness of the job.

(b) The evaluation should normally be no less than 20 hours in a period of seven consecutive days and should normally last no longer than 30 days.

(c) The evaluation does not establish any employer-employee relationship.

(d) A written report must evaluate the worker's performance in the areas originally identified for assessment.

(4) Labor market search.

(a) A labor market search is obtained from direct contact with employers, other actual labor market information, or from other surveys completed within 90 days of the report date.

(b) A labor market search is needed when 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 that must be addressed with employers to determine if a reasonable labor market exists.

(c) The person providing the information must have hiring responsibility or direct knowledge of the job's requirements and the job must exist at the firm contacted.

(d) The labor market search report must include, but is not limited to:

(A) Date of contact;

(B) Firm name, address, and telephone number;

(C) Name and title of person contacted;

(D) Qualifications of persons recently hired;

(E) Physical requirements;

(F) Wages paid;

(G) Condition of hire (full-time, part-time, seasonal, temporary);

(H) Date and number of last hire(s); and

(I) Available and anticipated openings.

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

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340(7)

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0443 Training - General

(1) Training services include but are not limited to plan development, training, monthly monitoring of training progress, and job placement services.

(2) The training plan must be developed and monitored by a counselor.

(3) The selection of plan objectives and the kind of training must attempt to minimize the length and cost of training necessary to prepare the worker for suitable employment.

(4) If there are any changes made to the original training plan, an addendum to [Form 1081](#), "Training Plan," must be completed, signed by all parties, and submitted to the division.

(5) Basic education may be offered, with or without other training components, to raise the worker's education to a level to enable the worker to obtain suitable employment.

(6) On-the-job training prepares the worker for permanent, suitable employment with the training employer and for employment in the labor market at large. On-the-job training must be considered first in developing a training plan.

(7) Occupational skills training is offered through a community college, based on a predetermined curriculum, at the training employer's location.

(8) Formal training may be offered through a vocational school licensed by an appropriate licensing body, community college, or other post-secondary educational facility that is part of a state system of higher education.

(9) Rehabilitation facilities training provides evaluation, training, and employment for severely disabled individuals.

(10) Notwithstanding OAR 436-120-0145(2)(a), 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.

(11) Training status continues during the following breaks:

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

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(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; or

(c) A period of illness or recuperation of the worker that does not prevent completion of the training by the planned date.

(12) The insurer must pay the worker temporary disability compensation, under ORS 656.268 and 656.340, when the worker is actively engaged in an authorized training plan and there is a [Form 1081](#), "Training Plan," signed by the worker, the insurer, and the counselor who developed the plan.

(13) Temporary disability compensation is limited for each eligibility period to 16 months unless extended to 21 months by the insurer or ordered by the director when the worker provides good cause. Good cause may include but is not limited to the reasons given under section (15) of this rule. In no event may temporary disability compensation during training be paid for more than 21 months.

(14) In addition to other requirements in OAR chapter 436, the insurer may not end temporary disability benefits until written notice under OAR 436-060-0015(7) has been mailed or delivered to the worker and the worker's attorney, if the worker is represented.

(15) Training costs may be paid for periods longer than 21 months. Reasons for extending training may include but are not limited to:

(a) Reasons beyond the worker's control;

(b) The worker has an exceptional disability, which is a disability equal to or greater than the complete loss, or loss of use, of both legs, or a brain injury that results in impairment equal or greater than Class 3 as defined in OAR 436-035-0390; or

(c) The worker has an exceptional loss of earning capacity, which exists when no suitable training plan of 18 months or less will eliminate the worker's substantial handicap to employment. The extension must allow the worker to obtain, at the time of completion of the training program, a wage that is as close as possible to the worker's adjusted weekly wage and greater than could be expected with a shorter training program.

(16) An eligible worker is entitled to four months of direct employment services after completion of training.

(17) When the worker returns to work following training, the insurer must monitor the worker's progress for at least 60 days to assure the suitability of the employment before ending eligibility.

(18) If the worker chooses a training plan period longer than the worker is entitled to receive under these rules, the worker may supplement training provided by the insurer by completing self-sponsored training or studies. For the purpose of this rule, self-sponsored means the worker is obligated to pay for the training.

(a) The first day of training provided by the insurer will be considered the training start date and the last day of training provided by the insurer will be the training end date.

(b) All self-sponsored training must be completed before the training start date unless the parties otherwise agree.

(c) During self-sponsored training, the insurer may provide optional services under OAR 436-120-0187, including but not limited to payment of expenses for tuition, fees, books, and supplies.

(d) The training plan support document must describe how the worker-sponsored training and the training provided by the insurer will combine to prepare the worker for suitable employment.

(19) The insurer must provide further training to a worker if the initial plan will not be or was not successful to prepare the worker for suitable employment.

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340, 656.262

Hist: Amended 12/19/22 as Admin. Order 22-070, eff. 1/1/24

Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0445 Training Requirements

(1) Basic education.

Basic education is limited to nine months unless extended by the insurer.

(2) On-the-job training.

(a) On-the-job training time is limited to 12 months unless extended by the insurer.

(b) The insurer must reimburse the training employer for a portion of the worker's wages.

(c) The on-the-job training contract between the training employer, the insurer, and the worker must include, but is not limited to:

(A) The worker's name;

(B) The employer's legal business name;

(C) The employer's current workers' compensation insurance policy number;

(D) The name of the individual providing the training;

(E) The training plan start and end dates;

(F) The job title and duties;

(G) The skills to be taught;

(H) The base wage and the terms of wage reimbursement;

(I) An agreement that the employer will pay all taxes normally paid on the entire wage and will maintain workers' compensation insurance for the trainee; and

(J) An acknowledgement that the training may not prepare the worker for jobs elsewhere, if the training prepares the worker for a job unique to the training site.

(d) The insurer must pay temporary disability compensation as provided in ORS 656.268.

(e) Unless there is a need to accommodate the worker's documented medical condition or class schedule, the worker's schedule must be the same as for a regular full-time employee.

(3) Occupational skills training.

(a) Occupational skills training is limited to 15 months unless extended by the insurer.

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(b) The training is primarily for the worker's benefit. The worker may not receive wages.

(c) Training does not establish any employer-employee relationship with the training employer. The training employer makes no guarantee of employing the worker when the training is completed.

(d) The training employer has a sufficient number of employees to accomplish its regular work and the training of the worker, and the worker does not displace an employee.

(e) Unless there is a need to accommodate the worker's documented medical condition or class schedule, the worker's schedule must be the same as for a regular full-time employee.

(4) Formal training.

(a) Formal training time is limited to 18 months unless extended by the insurer.

(b) Course load must be consistent with the worker's abilities and limitations and the length of time since the worker last attended school.

(c) Courses must relate to the vocational goal.

(5) Training before eligibility determined.

If the worker begins or completes training between the date of injury and the date of the eligibility determination, and then the insurer finds the worker eligible for vocational assistance and finds the worker's training suitable, the insurer must reimburse the worker for costs required by that training and verified by the insurer or the director, including temporary disability as required under ORS 656.268 and 656.340.

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0500 Training: Development and Implementation

(1) Collaborative effort.

A training plan should be a collaborative effort between the counselor and the worker and should include all the rights and responsibilities of the worker, the insurer, and the counselor.

(2) Review of the plan.

Before submitting the plan to the insurer, the counselor must review the plan and plan support with the worker. The worker must have the opportunity to review the plan with the worker's attorney, if any, before signing it. The counselor must confirm the worker's understanding of and agreement with the plan by obtaining the worker's signature.

(3) Copies of plan.

The counselor must submit copies of the plan, signed by the counselor and the worker, to all parties.

(4) Plan approval or disapproval.

Within 14 days of receipt of the signed training plan, the insurer must approve or disapprove the plan and notify the parties.

(a) If the insurer does not have enough information to approve or disapprove the training plan, the insurer must advise the

parties what information is needed and when the insurer expects to make a decision.

(b) If the insurer disapproves the training plan, the insurer must issue a NOTICE OF DISAPPROVAL OF TRAINING PLAN, which must explain why the plan is disapproved.

(5) Conference.

If the insurer does not approve a training plan within 90 days of determining the worker is entitled to a training plan, the insurer must contact the division within five days to schedule a conference.

(a) The purpose of the conference will be to identify and remove all obstacles to plan completion and approval.

(b) The insurer, the worker, the counselor, and any other parties involved in the process must attend the conference.

(c) The conference may be postponed for a period of time agreeable to the parties.

(d) The insurer or the worker may request a conference if other delays in the vocational rehabilitation process occur.

(6) Job offer during plan development.

If, during development of a training plan, an employer offers the worker a job, the insurer must perform a job analysis, obtain approval from the attending physician, verify the suitability of the wage, and confirm the offer is for a bona fide, suitable job. If the job is suitable, the insurer must help the worker return to work with the employer. The insurer must provide return-to-work follow-up during the first 60 days after the worker returns to work. If return to work with the employer is not feasible or, during the 60-day follow-up the job proves unsuitable, the insurer must immediately resume development of the training plan.

(7) Plan amendments.

(a) If the vocational goal is later changed, the insurer must amend the training plan. All amendments to the plan must be initialed by the insurer, counselor, and the worker.

(b) If the insurer amends a proposed plan, the insurer must indicate what the changes are and why they are necessary.

(8) Reporting to the director.

The training plan and any amendments must be submitted to the division using [Form 1081](#), "Training Plan."

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340(9)

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

436-120-0510 Training Plan Support

(1) Considerations in training plan.

The worker and counselor must work together to develop an appropriate training plan that considers the worker's:

(a) Transferable skills;

(b) Physical and mental capacities and limitations;

(c) Vocational interests;

(d) Educational background and academic skill level;

(e) Pre-injury wage; and

(f) Place of residence and that labor market.

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(2) Training plan documentation.

Training plan supporting documentation must contain, but is not limited to, the following:

- (a) Specific vocational goals and projected return-to-work wages;
- (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, Standard Occupational Classification (SOC) codes or other standardized job titles and codes, and specific job duties. The SOC codes can be found on the Oregon Employment Department OLMIS website at www.qualityinfo.org;
- (d) An explanation 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 counselor must explain why the goals are appropriate;
- (f) A summary of current labor market information that shows the labor market supports the vocational goals and documents that the worker has been informed of the condition of the labor market;
- (g) A labor market search as prescribed in 436-120-0410(4), if needed;
- (h) If the labor market information does not support the goals, the counselor must explain why the goals are appropriate. The worker and worker's representative, if any, must acknowledge in writing an awareness of the poor labor market conditions and a willingness to proceed with the plan in spite of these conditions. This acknowledgment must include an understanding the insurer will provide no additional training should the worker be unable to find suitable employment because of the labor market;
- (i) A job analysis prepared by the counselor, 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 must submit the resulting information to the attending physician for concurrence. If the attending physician has not responded within 30 days of the date of request for concurrence, the plan may proceed;
- (j) A signed on-the-job training contract, if applicable;
- (k) A description of the curriculum, which must be term-by-term if the curriculum is for formal training;
- (l) Information about the payment of temporary disability compensation while the worker is in training. If the training plan is for a longer period of time than temporary disability benefits may be paid, the plan must notify the worker that temporary disability benefits may end before training ends; and

(m) If material related to a plan is contained in a previous eligibility, the insurer may attach a copy of the evaluation to the plan.

Statutory authority: ORS 656.340(9), 656.726(4)
Statutes implemented: ORS 656.340
Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

436-120-511 Limited Training

(1) Eligibility. A worker who is not authorized to work in the United States is only eligible for limited training. The worker must meet all eligibility requirements under OAR 436-120-0145.

(2) Limited training plan requirements and benefits.

- (a) A limited training plan must meet all requirements and comply with limitations specified under OAR 436-120-0443, 436-120-0445, 436-120-0500, and 436-120-0510, unless otherwise specified under section (3) of this rule.
- (b) A limited training plan includes the vocational assistance specified under OAR 436-120-0443, 436-120-0445, 436-120-0500, and 436-120-0510, unless excluded under section (3) of this rule.
- (c) OAR 436-120-0520, 436-120-0523, 436-120-0527, and 436-120-0720 apply to limited training plans.

(3) Limited training plan exclusions.

- (a) Limited training may not include any of the following:
 - (A) On-the-job training;
 - (B) Direct employment services;
 - (C) Job placement services;
 - (D) Return-to-work monitoring under OAR 436-120-0443(17); or
 - (E) Return-to-work services under OAR 436-120-0500(6).
- (b) OAR 436-120-0197(1)(e) does not apply when a worker completes a limited training plan.

(4) Re-evaluation of limited training plan.

The insurer must reconsider the category of vocational assistance under OAR 436-120-0177(3) if the worker becomes authorized to work in the United States before or during a limited training plan. A worker who is authorized to work in the United States is eligible for direct employment services or training.

Statutory authority: ORS 656.340(9), 656.726(4)
Statutes implemented: ORS 656.340
Hist: Adopted 6/7/24 as WCD Admin. Order 24-054, eff. 7/1/24
See also the *Index to Rule History*:
https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-120-0520 Responsibilities of the Worker and the Counselor

(1) Worker responsibilities.

The worker is responsible for all of the following in a training plan:

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- (a) Actively participate in all aspects of the plan;
- (b) Maintain regular contact with the counselor throughout plan development and as required in the plan;
- (c) Notify the counselor if problems develop and continue to attend training during attempts to resolve the issue;
- (d) Inform the counselor immediately if anything threatens to interfere with successful completion of the program;
- (e) Notify the counselor by the close of the next working day if the worker stops attending training for any reason;
- (f) Maintain a 2.0 grade point average each grading period in formal training;
- (g) Complete the courses outlined in the curriculum by the plan end date;
- (h) Consult with the counselor before adding or dropping courses;
- (i) Provide a written training report to the counselor by the fifth day of each month;
- (j) Give the counselor a copy of each grade or progress report within 10 days of receipt; and
- (k) Meet all responsibilities agreed to in the plan.

(2) Counselor responsibilities.

The counselor is responsible for all of the following in a training plan:

- (a) During plan development, provide resource materials about jobs, training programs (if appropriate), labor markets and other related information to help the worker select a vocational goal; direct information gathering; and otherwise help the worker analyze and evaluate options;
- (b) Help the worker plan the curriculum and enroll. The counselor must contact the worker, trainers, and training facility counselors to the extent necessary to assure the worker's participation and progress;
- (c) Contact the worker on a regular basis;
- (d) Monitor and evaluate the plan at least monthly;
- (e) Contact the worker's trainers and training site counselors, as necessary to ensure the worker's participation and progress meet the requirements of the rules and are satisfactory to achieve the return-to-work objectives;
- (f) Report potential problems in the program to the insurer immediately including additional needs of the worker;
- (g) Advise the insurer within one business day of learning of any circumstance indicating a probable or actual interruption in the worker's entitlement to temporary disability benefits;
- (h) Provide job-search skills and job development as necessary; and
- (i) Meet any responsibilities agreed to in the plan.

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

436-120-0523 Re-evaluating a Training Plan

(1) Reasons to re-evaluate a plan.

The insurer must re-evaluate a training plan and modify or replace the plan when appropriate to ensure the worker's success, when:

(a) A change occurs in the worker's limitations that may make the training inappropriate; or

(b) In an academic program:

(A) There is an indication the worker may not maintain at least a 2.0 grade point average for two grading periods; or

(B) There is an indication the worker may not complete the minimum credit hours required under the training plan.

(2) Academic program.

In an academic program:

(a) The counselor must notify the insurer, and the insurer may give the worker a written warning of the possible end of training, when the worker:

(A) Fails to maintain a 2.0 grade point average for two consecutive grading periods; or

(B) Fails to complete the minimum credit hours in the training plan curriculum.

(b) If the insurer is going to end training for a reason listed in subsection (a), the worker must be given a written warning before training is ended.

(3) Non-academic program.

In a non-academic program, the counselor must notify the insurer, and the insurer may give the worker a written warning of the possible end of training, at the first indication that the worker's performance in training is unsatisfactory and may not result in employment in that field.

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended and renumbered 11/28/16 from 436-120-0448, as Admin. Order 16-058, eff. 1/1/17

436-120-0527 Ending a Training Plan

(1) Reasons to end training.

Training ends when:

(a) The worker has successfully completed training;

(b) The worker's eligibility for vocational assistance has ended under OAR 436-120-0165;

(c) The worker is not actively engaged in the training;

(d) The worker fails, after written warning, to maintain at least a 2.0 grade point average for two consecutive grading periods;

(e) The worker fails, after written warning, to complete the minimum credit hours in the training plan curriculum for two consecutive grading periods;

(f) In a non-academic program, the worker's performance in training is unsatisfactory and further training is not likely to result in employment in that field; or

(g) The training plan was not going to be successful due to reasons beyond the worker's control.

(2) Notice of end of training.

When training ends, the insurer must mail a NOTICE OF END OF TRAINING to the worker. The notice must:

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(a) Include the date the training plan ended. The effective date is the worker's last date of attendance; and

(b) State whether the worker is entitled to more training.

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended and renumbered 11/28/16 from 436-120-0451, as Admin. Order 16-058, eff. 1/1/17

436-120-0530 Director Review of Return-to-Work Plan

The director may review return-to-work plans and supporting information. If the director finds a return-to-work plan or its supporting information does not conform to these rules:

(1) The director will notify the insurer and 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 must, within 30 days of notification, make appropriate changes, supply additional information requested by the director, or explain why no change should be made.

(3) If the insurer does not respond timely or is unable to bring the plan into conformance, the director will return the plan to the parties with notification that the plan does not conform to OAR 436-120 and may order the insurer to develop a plan that conforms to the rules.

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

436-120-0700 Direct Worker Purchases

(1) Purchases, generally.

(a) The insurer must provide the direct worker purchase categories listed in OAR 436-120-0710 as necessary for the worker's participation in vocational assistance and to meet the requirements of a suitable job.

(b) The worker is no longer eligible for these purchases once eligibility ends unless the purchases are necessary to complete a plan.

(c) Direct worker purchases include partial purchase, lease, rental, and payment.

(2) Exclusions.

Direct worker purchases do not include:

(a) Purchases of real property;

(b) Payment of fines or other penalties; or

(c) Payment of additional driver's license costs, increased insurance costs, or any other costs attributable to problems with the worker's driving record.

(3) Alternative purchases.

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 that is more expensive than that authorized by the insurer, the worker may select that alternative and pay the difference in cost.

(4) Approval or denial.

Within 14 days of its receipt of a request for a direct worker purchase, the insurer must approve the purchase or notify the worker of its denial.

(5) Payment.

The insurer must pay for approved direct worker purchases in time to prevent delay in the provision of services, but in no event later than 30 days after the insurer receives the worker's request or proof of payment, whichever is later.

(6) Advancement of costs, worker reimbursement.

The worker may pay for mileage, child or senior care, or for purchases such as clothing, books, and supplies or the worker may request an advance of any of these costs based on documentation of need.

(a) The insurer must reimburse costs within 30 days of receiving a written request from the worker and any supporting documentation.

(b) The insurer must return denied requests for reimbursement to the worker within 30 days of receiving the request with an explanation of the reason for nonpayment.

(7) Right and title to nonexpendable purchases.

The insurer must assign to the worker right and title to the nonexpendable direct worker purchases paid by the insurer.

(a) The insurer must 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.

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

436-120-0710 Direct Worker Purchases: Categories

The insurer must provide the direct worker purchases listed in this rule if necessary for the worker to participate in vocational assistance or to meet the requirements of a suitable job. The insurer may not require the worker to submit a financial statement in order to qualify for direct worker purchases.

(1) Tuition, fees, books, and supplies.

Payment for tuition, fees, books, and supplies for training or studies is limited to those items identified as mandatory by the instructional facility, trainer, or employer. The insurer must pay the cost in full, and may not require the worker to apply for grants to pay for tuition, books, or other expenses associated with training.

(2) Wage reimbursement.

The amount of wage reimbursement for on-the-job training must be agreed to in a contract between the training employer and the insurer.

(3) Travel expenses.

Travel expenses for transportation, meals, and lodging that are required for participation in vocational assistance, including but not limited to job search, required meetings with the counselor,

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and meetings with employers or at training sites as required by the plan or plan development. The conditions and rates for payment of travel expenses are as follows:

(a) Transportation costs will be paid at public transportation rates when public transportation is available; otherwise, mileage will be paid at the rate published in [Bulletin 112](#). Costs incidental to mileage, such as parking fees, also will be paid. For workers receiving temporary total disability or equivalent income, private car mileage will 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 will 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) For overnight travel, meal and lodging expenses will be reimbursed at the rate published in [Bulletin 112](#).

(c) Payment for special travel costs will be made in excess of the amounts specified in this section 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.

Payment for tools and equipment for training or employment is limited to items identified as mandatory for the training or initial employment, such as starter sets. Purchases may not include what the trainer or employer ordinarily would provide to all employees or trainees in the training or employment, or what the worker already owns.

(5) Moving expenses.

Payment for moving expenses is limited to workers with employment or training outside reasonable commuting distance. In determining the necessity of paying moving expenses, the insurer may consider the availability of employment or training that does not require moving, or that requires less than the proposed moving distance. Payment is limited to moving household goods weighing not more than 10,000 pounds. If necessary, payment includes reasonable costs of meals and lodging for the worker's family and mileage under section (3) of this rule.

(6) Second residence allowance.

The purpose of the second residence allowance is to enable the worker to participate in training outside reasonable commuting distance. The allowance must equal the rental expense reasonably necessary, plus not more than \$500 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 a permanent residence.

(7) Primary residence allowance.

The primary residence allowance applies when the worker must change residence for training or employment. Payment includes the first month's rent and the last month's rent only if required before moving in.

(8) Medical and psychological examinations.

Payment for medical examinations and psychological examinations must be for conditions not related to the compensable injury when necessary for determining the worker's ability to participate in vocational assistance.

(9) Physical or work capacities evaluations.

(10) Living expense allowance.

Payment for living expenses is limited to workers involved in an on-the-job vocational evaluation at least 20 hours in a period of seven consecutive days, and not receiving temporary disability payments. The amount of the allowance is equivalent to the amount that would be paid for temporary total disability for the duration of the evaluation if the worker's claim were reopened.

(11) Work adjustment, on-the-job evaluation, or situational assessment costs.

(12) Membership fees and occupational certifications, licenses, and related testing costs.

Payment for membership fees, occupational certifications and licenses, and related testing costs is limited to \$500.

(13) Clothing.

Clothing purchases may not include items the trainer or employer would provide or the worker already possesses.

(14) Child or disabled adult care services.

Child or disabled adult care services are payable when required to enable the worker to participate in vocational assistance at rates prescribed by the Oregon Department of Human Services. For workers receiving temporary total disability compensation or equivalent income, these costs will 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 in [Bulletin 124](#).

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

Payment for dental work, eyeglasses, hearing aids, and prosthetic devices is required even if not related to the compensable injury if they will enable the worker to obtain suitable employment or participate in training.

(16) Union dues and fees.

Payment for labor union dues and fees is limited to initiation fees, or back dues and one month's current dues.

(17) Vehicle rental or lease.

Payment for vehicle rental or lease is required when there is no reasonable alternative enabling the worker to participate in vocational assistance or accept an available job. The worker must provide the insurer with proof of a valid driver's license and insurance coverage. Payment is limited to \$3,300.

(18) Other purchases.

Payment for other purchases the insurer considers necessary for the worker's participation in vocational assistance is limited to \$2,600.

Statutory authority: ORS 656.340(9), 656.726(4)
Statutes implemented: ORS 656.340

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

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436-120-0720 Fee Schedule

(1) The director has established the fee schedule in section (3) of this rule for professional costs and direct worker purchases. The schedule sets maximum spending limits per claim opening for each category; however, the insurer may spend more than the maximum limit. Spending limits will be adjusted annually, effective July 1, based on the conversion factor published with the cost-of-living matrix in [Bulletin 124](#).

(2) For workers needing an extended training plan under OAR 436-120-0443, the fee schedule spending limits for the Training category and Direct Employment/Training Combined category listed below must be increased by 30 percent.

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(3) Amounts include professional costs, travel and wait time, and other travel expenses:

Categories of Vocational Assistance	Professional Spending Limits	Direct Worker Purchases Spending Limits
Eligibility determination without substantial handicap analysis	55%	Not applicable (NA)
Substantial handicap analysis	109%	NA
Direct Employment	736%	368%
Training or Limited Training	1840%	2429%
Direct Employment/Training Combined	2045%	NA
Dispute Resolution	61%	NA

NOTE: *Each limit is shown as a percentage of Oregon's state average weekly wage (SAWW), determined under ORS 656.211. Dollar amounts are published in [Bulletin 124](#) and are adjusted annually, effective July 1, based on changes in the SAWW.

(4) The insurer must pay, within 60 days of receipt, the provider's bill for services provided under the insurer-provider agreement. The insurer may 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.

Statutory authority: ORS 656.340(9), 656.726(4)
Statutes implemented: ORS 656.340, 656.258
Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17
Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0755 Reimbursement from the Workers' Benefit Fund

(1) Reimbursement.

The director will reimburse the insurer for costs associated with providing vocational benefits when:

(a) The director issues an order overturning the insurer's denial of vocational benefits; and

(b) The insurer's denial is later upheld by a final order.

(2) Required documentation.

To receive reimbursement from the Workers' Benefit Fund, the insurer must provide the division with the following documentation, within one year from the date of the final order:

(a) Worker's name and Workers' Compensation Division's claim file number;

(b) Date and order number of the director's order appealed;

(c) Itemized listing with dates of service for all costs incurred after the date of the director's order that was reversed. All costs, in order to be reimbursed, must meet all conditions set forth in these rules, and reimbursement requests must:

(A) Use terms, "direct employment" or "training" to show the category of vocational assistance provided;

(B) List provider costs by category of "professional services";

(C) List direct worker purchases by the categories in OAR 436-120-0710, and include purchase dates and costs;

(D) Show temporary total disability paid between the start and end dates of the return to work plan; and

(E) List any other costs incurred in providing vocational benefits as a result of the order that was appealed.

(d) Signed statement certifying that the requested reimbursement amount was actually paid; and

(e) The insurer's name and address where reimbursement is to be sent.

(3) Administrative costs not reimbursable.

No reimbursement is allowed for the insurer's administrative costs.

Statutory authority: 656.726(4)
Statutes implemented: Oregon Laws 2005, chapter 588, sections 4 & 5; ORS 656.313, 656.605
Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

436-120-0800 Registration of Providers

(1) A provider may not provide vocational assistance services unless the provider is first registered by the director under this rule.

(2) A provider must submit an application, [Form 2814](#), "Vocational Assistance Certification Program Registration of Vocational Assistance Provider," to the division that includes a description of the specific vocational services to be provided and verification of staff certifications under these rules.

(3) The director may approve or deny registration based on the completed application and the department's registration and counselor certification records.

(a) The registration will specify the scope of authorized vocational services as determined by the provider's staff certifications.

(b) Providers whose registration is denied under this rule may appeal as described in OAR 436-120-0008.

(4) A registered provider must:

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

(b) Maintain worker vocational assistance files for four years after the end of vocational assistance with that provider.

Statutory authority: ORS 656.340(9), 656.726(4)
Statutes implemented: ORS 656.340
Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

436-120-0810 Certification and Classification of Provider Staff

(1) Certification, generally.

(a) Individuals determining workers' eligibility and providing vocational assistance must be certified by the director and on the staff of a provider.

(b) An applicant for certification must submit [Form 1880](#), "Vocational Assistance Certification Program Individual Certification Under OAR 436-120," to the division.

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(c) All degrees required for certification must be from an accredited institution and copies of transcripts must be submitted with the application.

(d) If the director approves the application, certification will be granted for five years. A counselor who is nationally certified as described in subparagraph (3)(a)(B)(i) will be granted an initial certification period to coincide with the counselor's national certification.

(e) Certified individuals must notify the division within 30 days of any changes in address or telephone number.

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

(2) Classification of provider staff.

Certified individuals will be classified as follows:

- (a) Vocational assistance counselor;
- (b) Vocational assistance intern; or
- (c) Return-to-work specialist.

(3) Certification requirements.

The requirements for certification as a counselor, intern, or specialist are as follows:

- (a) Vocational assistance counselor.

(A) Certification as a counselor allows the individual to determine eligibility for vocational assistance and provide vocational assistance services.

- (B) Counselor certification requires:

(i) Certification by one of the following national certifying organizations:

(I) The Commission on Rehabilitation Counselor Certification (CRCC);

(II) The Commission for Case Managers Certification (CCMC); or

(III) The Certification of Disability Management Specialists Commission (CDMSC);

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

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

(iv) 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.

(C) To meet the direct experience requirements for a counselor, the individual must:

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

(ii) Perform three or more of the qualifying job functions listed in sub-subparagraphs (I) through (X) for the required number of months, with at least six months of the experience in one or more of the functions listed in sub-subparagraphs (I) through (IV). The qualifying job functions are:

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

(II) Employment counseling;

(III) Job development;

(IV) Early return-to-work assistance that includes working directly with workers and their employers;

(V) Vocational testing;

(VI) Job search skills instruction;

(VII) Job analysis;

(VIII) Transferable skills assessment or employability evaluations;

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

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

- (b) Vocational assistance intern.

(A) Certification as a vocational assistance intern allows the individual to determine eligibility for vocational assistance and provide vocational assistance services under the direct supervision of a counselor. A counselor must co-sign and assume responsibility for all of the intern's actions.

- (B) Intern certification requires:

(i) A master's degree in psychology, counseling, or a field related to vocational rehabilitation; or

(ii) A bachelor's degree and at least six hours of training on the Oregon vocational assistance and re-employment assistance rules. Thirty-six months of direct experience may substitute for a bachelor's degree.

(C) To meet the direct experience requirements for an intern, the individual must:

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

(ii) Perform three or more of the qualifying job functions listed in subparagraph (3)(a)(C)(ii) of this rule for the required number of months.

- (c) Return-to-work specialist.

(A) Certification as a return-to-work specialist allows the individual to provide job search skills instruction, job development, return-to-work follow-up, and labor market search, and to determine eligibility for vocational assistance except when the determination requires a judgment as to whether the worker has a substantial handicap to employment.

(B) Specialist certification requires 24 months of direct experience. Full-time (or the equivalent) additional college coursework in psychology, counseling, education, a field related to human services, or a field related to vocational rehabilitation may substitute for up to 18 months of direct experience, on a month-for-month basis.

(C) The direct experience requirements for a specialist are the same for an intern, as described in paragraph (b)(C) of this section.

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

(A) Perform one or more of the qualifying job functions listed in subparagraph (3)(a)(C)(ii) of this rule at least 50 percent of

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the work time for each month of direct experience credit. Qualifying job functions performed in a job that is less than full-time will be prorated. For purposes of this rule, full-time is 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.

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

436-120-0820 Renewal of Certification

(1) Required documentation.

A certified individual must renew their certification every five years by submitting Form 1880, "Vocational Assistance Certification Program Individual Certification under OAR 436-120," and the following documentation to the division no later than 30 days before the end of the certification period:

(a) Current certification by the Commission on Rehabilitation Counselor Certification (CRCC), the Commission for Case Managers Certification (CCMC), or the Certification of Disability Management Specialists Commission (CDMSC); or

(b) Verification of a minimum of 60 hours of continuing education units under this rule within the five years before renewal.

(2) Continuing education.

(a) The director will accept continuing education units for:

(A) Training approved by the CRCC, CCMC, or CDMSC;

(B) Courses in or related to psychology, sociology, counseling, or vocational rehabilitation, if given by an accredited institution of higher learning;

(C) Training presented by the division pertaining to OAR 436-120, 436-105, or 436-110;

(D) Teaching a class or making a formal presentation to a group on a topic related to vocational rehabilitation; and

(E) Any continuing education program certified by the director for providers. Sixty minutes of continuing education will count as one unit, except as noted in subsection (b) of this section.

(b) In the case of college course work, the director 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.

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

Amended 6/13/22 as Admin. Order 22-060, eff. 7/1/22

Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0840 Professional Standards for Providers and Counselors

(1) Providers and counselors must:

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

(b) Fully inform the worker of the categories and kinds of vocational assistance under OAR 436-120 and re-employment assistance under OAR 436-110;

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

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

(e) Recommend workers only for suitable employment;

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

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

(2) Providers and counselors may not:

(a) Provide evaluations or assistance if there is a conflict of interest or 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 provider or counselor 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, misrepresent, or make a serious error or omission in connection with an application for registration or certification;

(f) Commit fraud, misrepresent, or make a serious error or omission in connection with a report or return-to-work plan or the vocational assistance activities or responsibilities of a provider under OAR chapter 436;

(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;

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

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

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.313, 656.340

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

Amended 6/7/24 as Admin. Order 24-054, eff. 7/1/24

436-120-0900 Audits, Penalties, and Sanctions

(1) Insurers and employers at injury must fully participate in any department audit, periodic program review, investigation, or review, and provide records and other information as requested.

(2) If the director finds the insurer or employer at injury failed to comply with OAR 436-120, the director may impose one or more of the following sanctions:

(a) Reprimand by the director;

(b) Recovery of reimbursements;

(c) Denial of reimbursement requests; or

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(d) A civil penalty under ORS 656.745.

(3) In determining the amount of a civil penalty to be assessed the director may consider:

(a) The degree of harm inflicted on the worker;

(b) Whether there have been previous violations or warnings; and

(c) Other matters as justice may require.

Statutory authority: ORS 656.340, 656.726(4)

Statutes implemented: ORS 656.340, 656.447, 656.745(1) and (2)

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

436-120-0915 Sanctions of Providers and Counselors

(1) Providers and counselors must fully participate in any department audit, periodic program review, investigation, or review, and provide records and other information as requested.

(2) If the director finds any provider or counselor failed to comply with OAR 436-120, the director may impose one or more of the following sanctions:

(a) Reprimand by the director;

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

(c) Suspension, which is the termination of registration or certification to determine eligibility and provide vocational assistance to Oregon injured workers for a specified period of time. The provider or counselor may reapply for registration or certification at the end of the suspension period. If granted, the provider or counselor will be placed on probation as described in subsection (2)(b) of this rule; or

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

(3) The director will investigate violations of OAR 436-120 and may impose a sanction under these rules. Before issuing a suspension or revocation, the director will send a notice of the proposed action and provide the opportunity for a show-cause hearing as follows:

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

(b) The provider or counselor has 10 days from the date of receipt of the notification of proposed action in which to request a show-cause hearing.

(c) If the provider or counselor does not request a show-cause hearing, the proposed suspension or revocation will become final.

(d) If the provider or counselor requests a show-cause hearing, the director will send a notification of the date, time, and place of the hearing.

(e) After the show-cause hearing, the director will issue a final order that may be appealed as described in OAR 436-120-0008(3).

(4) For the purposes of section (3) of this rule, "show-cause hearing" means an informal meeting with the director in which the provider or counselor will be provided an opportunity to be heard and present evidence regarding any proposed actions by the director to suspend or revoke a provider or counselor's authority to provide vocational assistance services to injured workers.

(5) The director may bar a provider or counselor who has received a suspension or revocation under this rule from sponsoring or teaching continuing education programs.

Statutory authority: ORS 656.340(9), 656.726(4)

Statutes implemented: ORS 656.340

Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 140
CONSTRUCTION CARVE-OUT PROGRAMS

Effective Jan. 1, 2020

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436-140-0001 Authority For Rules

These rules are promulgated under the director's authority pursuant to ORS 656.726(4) and 656.174.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0002 Purpose

The purpose of these rules is to implement ORS 656.170 and 656.172, and to establish and provide procedures and requirements for the administration and enforcement of programs entered into under ORS 656.170 and 656.172.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0003 Applicability of Rules

(1) These rules shall be applicable on their effective date and thereafter to carry out the provisions of ORS 656.170 and 656.172.

(2) Notwithstanding sections 2 and 3, chapter 841, Oregon Laws 1999 (ORS 656.170 and 656.172), prior to January 1, 2002 the director may issue letters of eligibility to only two qualified unions for participation in an alternative dispute resolution system authorized under section 2 of the 1999 Act

(656.170). The director may not issue letters of eligibility after January 1, 2002.

(3) These rules apply to parties to a collective bargaining agreement only insofar as **and** only to the extent that the agreement contains the provisions provided by ORS 656.170, has been approved by the director, and for which eligibility has been established under these rules.

(4) Except as otherwise provided by law, the provisions of ORS Chapter 656, OAR Chapter 436, and OAR Chapter 438 apply to programs entered into under these rules, unless the collective bargaining agreement expressly specifies otherwise.

(5) Applicable to this chapter, the director may, unless otherwise obligated by statute, waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0005 Definitions

For the purpose of these rules, unless the context requires otherwise:

(1) "**Alternative dispute resolution system**" means a process that exists outside the normal Workers' Compensation system to settle disputes arising from a workers' compensation claim.

(2) "**Arbitration**" means the hearing and determination of a case in controversy by an arbiter.

(3) "**Collective bargaining representative**" means a person who represents a union.

(4) "**Construction carve-out program**" means a program established pursuant to ORS 656.170 and 656.172 for either an alternative dispute resolution system or use of a list of medical service providers, or both, which the director has approved and for which eligibility has been established under these rules.

(5) "**Director**" means the Director of the Department of Consumer and Business Services, or the director's delegate for the matter.

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

(7) "**Employer**" is limited to a private employer, or group of employers, engaged in construction; construction maintenance; or activities limited to rock, sand, gravel, cement and asphalt operations; heavy duty mechanics; surveying; or construction inspection.

(8) "**Employee**" is limited to an employee of an employer defined by section (7) of this rule.

(9) "**Insurer**" includes "**insurer**," "**guaranty contract insurer**," and "**self-insured employer**" as defined by ORS 656.005.

(10) "**Letter of eligibility**" means a letter issued by the director under ORS 656.172(4) indicating that eligibility to participate in a construction carve-out program has been established under ORS 656.170 and ORS 656.172.

(11) "**Mediation**" means the act or process of intervening between conflicting parties to promote reconciliation, settlement, or compromise.

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(12) "Plan administrator" means the person responsible for administering the Construction Carve-Out Program.

(13) "Union" means a collective bargaining union that is recognized or certified as the exclusive bargaining representative of employees for an employer or group of employers.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0006 Administration of Rules

Any orders issued by the division in carrying out the director's authority under ORS Chapter 656 and these rules are considered orders of the director.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0008 Administrative Review

(1) If the director determines that a proposed construction carve-out program is not eligible, the director will issue a notice to the employer or collective bargaining representative.

(a) Under ORS 656.704(2), if the employer or collective bargaining representative disagrees with the notice, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the notice.

(b) OAR 436-001 applies to the hearing.

(2) If the director determines that the acts or omissions of a construction carve-out program justify suspension, the director may issue a notice of intent to suspend eligibility pursuant to OAR 436-140-0090 and schedule a hearing on the matter of suspension. The notice must be served upon the employer or collective bargaining representative as provided in OAR 436-140-0130.

(a) At a hearing on a notice of intent to suspend, the employer or collective bargaining representative must show cause why eligibility should not be suspended.

(A) If the director determines that the acts or omissions of the employer or collective bargaining representative justify suspension, the director may issue an order suspending eligibility. If the director determines that the acts or omissions of the employer or collective bargaining representative do not justify suspension, the director shall issue an order withdrawing the notice.

(B) The order must be served upon the employer or collective bargaining representative as provided in OAR 436-140-0130.

(C) If the employer or collective bargaining representative disagrees with the order, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(D) OAR 436-001 applies to the hearing.

(3) If the director determines that the acts or omissions of a construction carve-out program justify revocation, the director may issue a notice of intent to revoke eligibility pursuant to OAR 436-140-0090. The notice must be served upon the

employer or collective bargaining representative as provided in OAR 436-140-0130.

(a) The revocation shall become effective within 10 days after service of notice, unless within such period of time the employer or collective bargaining representative correct(s) the grounds for revocation to the satisfaction of the director or files a written request for hearing with the director.

(A) If the employer or collective bargaining representative request(s) a hearing, the director will set a date and time, and give at least 10 days' notice of the hearing. At hearing, the employer or collective bargaining representative must show cause why eligibility should not be revoked.

(B) Within 30 days after the hearing, the director shall issue an order affirming or withdrawing the revocation. The director shall serve a copy of the order upon the employer or collective bargaining representative as provided in OAR 436-140-0130.

(C) If the employer or collective bargaining representative disagrees with the order, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(D) OAR 436-001 applies to the hearing.

(b) An emergency revocation issued pursuant to OAR 436-140-0090(5), is effective immediately. To contest the revocation, the employer or collective bargaining representative must file a request for hearing within 60 days of the mailing date of the order; the revocation shall remain in effect until the director orders otherwise. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174, 656.704, OL 2005 ch 26

Hist.: Amended 10/19/05 as WCD Admin. Order 05-069, eff. 1/2/06

436-140-0010 Qualifying

(1) An employer, group of employers or collective bargaining representative may not establish or continue to participate in a construction carve-out program under ORS 656.170 until the proposed program has been approved by the director and the director has issued a letter of eligibility. An application containing the information described in subsections (2) and (3) of this rule must be submitted to the director.

(2) The employer or group of employers must provide at least the following:

(a) Payroll records sorted by National Council on Compensation Insurance (NCCI) classification for one of the three years prior to the year in which the collective bargaining agreement takes effect.

(b) A proposed plan for the construction carve-out program, along with four copies, in which it is demonstrated how the proposed construction carve-out program will meet the requirements of ORS 656.170, 656.172, and these rules;

(c) A copy of the collective bargaining agreement;

(d) An estimate of the number of employees covered by the collective bargaining agreement;

(e) A copy of a valid license when that license is required of the employer or group of employers to conduct business in Oregon;

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(f) A signed, sworn statement that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement;

(g) The name, address, and telephone number of the contact person of the employer or group of employers;

(h) A statement from the insurer or self-insured employer that the insurer or self-insured employer is willing to insure the risk under the terms of the collective bargaining agreement; and

(i) If applicable, a list of the names, addresses, and specialties of the medical service providers who will provide medical services under the construction carve-out program, together with appropriate evidence of any licensing, registration or certification requirements for that individual to practice. This list shall indicate which medical service providers will act as attending physicians.

(3) The collective bargaining representative must provide at least the following:

(a) A copy of the most recent LM-2 or LM-3 filing with the United States Department of Labor, and a signed, sworn statement that the document is a true and correct copy; and

(b) The name, address, and telephone number of the contact person for the collective bargaining representative.

(4) Within 45 days of receipt of the information required by subsections (2) and (3), the director will notify the applicants that the program is or is not approved. A letter of eligibility will be issued if the program is approved. If the program is not approved, a notice will be issued. The notice will include the reasons the program is not approved and a notice of appeal rights under OAR 436-140-0008(1). The notice will be served upon the employer and/or collective bargaining representative as provided in OAR 436-140-0130.

(5) Upon issuance of a letter of eligibility, those provisions of the collective bargaining agreement or other documents entered into under ORS 656.170(1) are considered valid and binding, subject to the terms of the agreement.

(6) One in-state location shall be established where the construction carve-out program is administered and records are maintained.

(7) No construction carve-out program shall be approved that diminishes the entitlement of an employee to compensation as provided by ORS Chapter 656.

(8) No more than two unions may qualify for participation in a construction carve-out program. In establishing qualification, the director will process all applications in the order in which they are received.

(9) The employer, or group of employers, and collective bargaining representative shall meet the reporting requirements under OAR 436-140-0070 in order to continue to participate in a construction carve-out program.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0020 Alternative Dispute Resolution

(1) A construction carve-out program may establish and operate an alternative dispute resolution system governing disputes between employees, employers, and their insurers. Any such system may include, but not be limited to:

(a) Limitations on the liability of the employer while determinations regarding the compensability of an injury are being made;

(b) A method for resolving disputes involving compensability of injuries and the amount of compensation due for a compensable injury, medical services, and legal services;

(c) A method for payment of compensation for injuries incurred under the collective bargaining agreement, when the worker is no longer subject to the agreement; or

(d) Arbitration and mediation procedures.

(2) If a construction carve-out program establishes an alternative dispute resolution

system, a dispute to which that system applies shall first be processed through that system before it is brought before another forum.

(3) The plan administrator shall provide a written summary of the alternative dispute resolution system process to all parties to a dispute, or upon request. The written summary shall include at least the following:

(a) The title, address, and telephone number of a contact person for the alternative dispute resolution system process;

(b) The types of disputes to which the alternative dispute resolution system will apply and the types of disputes, if any, to which the dispute resolution processes provided by ORS Chapter 656, OAR Chapter 436, and/or OAR Chapter 438 will apply;

(c) A description of the procedures and time frames at each level of the alternative dispute resolution system process; and

(d) A statement of the right of an aggrieved party to request review by the Workers' Compensation Board, and reference to the applicable Board rules, after completion of the alternative dispute resolution system process.

(4) Written notification must be provided to all parties, including the worker's attorney if the worker is represented, when the alternative dispute resolution system receives a dispute for resolution and when the dispute resolution system issues any decision in that dispute. The notice shall inform the parties of the status of the dispute, and of the next level of the dispute resolution process.

(5) The time frame for resolution of a dispute by the alternative dispute resolution system, from date of receipt of a dispute until agreement or completion of the highest level of the system, including issuance of a final decision, shall not exceed 180 days without approval of all parties.

(6) The director may, at any time and/or upon request, issue an order to further the dispute resolution system process.

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(7) The alternative dispute resolution system shall develop a record sufficient for any party to appeal a decision by the alternative dispute resolution system.

(8) An aggrieved party to any decision, order or award of compensation issued under the alternative dispute resolution system may request review by the Workers' Compensation Board in accordance with Chapter 656 and OAR Chapter 438 after completion of the alternative dispute resolution system.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0030 Medical Services

(1) A construction carve-out program may establish a list of medical service providers that the parties agree is the exclusive source of all medical treatment provided under ORS chapter 656.

(2) A construction carve-out program shall establish a method for access to medical services for workers no longer subject to the agreement when those injuries were sustained under the collective bargaining agreement.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0040 Compensation

Benefit amounts that exceed the statutory rates under ORS Chapter 656 shall not be subject to reimbursement from the Workers' Benefit Fund.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0045 Multiple Claims; Expiration or Termination of Collective Bargaining Agreement; Responsibility

(1) Disputes involving multiple claims when one or more of the claims are not subject to the collective bargaining agreement shall be resolved pursuant to ORS 656.307, 656.308, and OAR Chapter 436.

(2) Upon expiration of the collective bargaining agreement without renewal, or after termination of any arrangement under ORS 656.170 and 656.172, the insurer is responsible for benefits and claims in accordance with the provisions of ORS Chapter 656 unless otherwise provided for under the agreement.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0050 Duties and Responsibilities of Employer

(1) An employer or group of employers that participates in a construction carve-out program shall comply with coverage requirements under ORS 656.017.

(2) The participating employer or group of employers shall report all claims made under the program to the insurer as with other claims.

(3) The participating employer or group of employers shall comply with the terms of the collective bargaining agreement and construction carve-out program.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0060 Insurer Duties and Responsibilities

(1) An insurer who contracts to provide coverage to an employer or group of employers under a construction carve-out program shall timely report claims made under the construction carve-out program to the director.

(2) The insurer shall provide benefits in accordance with the terms of the collective bargaining agreement and construction carve-out program.

(3) The insurer shall segregate all loss and payroll data for reporting and research purposes. Data shall be forwarded to the director upon request.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0070 Reporting Requirements

(1) In order to ensure the construction carve-out program continues to comply with the eligibility requirements of these rules, the employer, or group of employers, and collective bargaining representative shall:

(a) upon renegotiation of the collective bargaining agreement, provide the director with a copy no less than 30 days before the agreement takes effect, including an estimate of the number of employees covered by the agreement; and

(b) on an annual basis, provide the director the following:

(A) A copy of a valid license when that license is required of the employer or group of employers to conduct business in Oregon;

(B) A signed, sworn statement that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement;

(C) The name, address, and telephone number of the contact person of the employer or group of employers;

(D) A statement from the insurer or self-insured employer that the insurer or self-insured employer is willing to insure the risk under the terms of the collective bargaining agreement;

(E) A copy of the most recent LM-2 or LM-3 filing with the United States Department of Labor, and a signed, sworn statement that the document is a true and correct copy; and

(F) The name, address, and telephone number of the contact person for the collective bargaining representative.

(2) Upon request of the director, a construction carve-out program shall provide a listing by category of medical service providers, including provider names, specialty, Tax ID number, Oregon license number, business address and phone number. The listing shall include all health care providers participating in the construction carve-out program.

(3) Nothing in this rule limits the director's authority to require information as necessary to monitor compliance with these rules.

(4) The plan administrator and/or insurer may apply to the director for approval to modify forms or notices required by

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rule or bulletin. No modified form or notice shall be used without the director's prior approval.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0090 Suspension or Revocation

(1) Prior eligibility of a construction carve-out program may be suspended or revoked if any of the following occur:

(a) the director finds a serious danger to the public health or safety;

(b) the construction carve-out program fails to provide services under the terms of the collective bargaining agreement;

(c) the employer, or group of employers, collective bargaining representative, and/or insurer fails to comply with ORS Chapter 656, OAR 436-140, or orders of the director; or

(d) the employer, or group of employers, collective bargaining representative, and/or insurer submits any false or misleading information pertaining to the eligibility.

(2) The director shall provide written notice of intent to suspend or revoke eligibility.

(a) The notice shall:

(A) describe generally the acts and the circumstances that would be grounds for suspension or revocation; and

(B) advise of the right to a hearing in the case of revocation; and the date, time and place of the hearing in the case of suspension.

(b) The notice shall be served as provided in OAR 436-140-0130.

(3) The hearing shall be conducted as provided in OAR 436-140-0008.

(4) Suspension or revocation shall have the effect of removing director approval and eligibility of the construction carve-out program. A revoked program will have to re-apply for director approval and a letter of eligibility to be effective.

(5) Notwithstanding any other provision of this rule, in any case where the director finds a serious danger to the public health or safety and sets forth specific reasons for such findings, the director may immediately revoke the eligibility of a construction carve-out program without opportunity for a hearing. The order must be served upon the employer and/or collective bargaining representative as provided in OAR 436-140-0130. Such order shall be final, unless the parties request a hearing. The process for review shall be as provided in OAR 436-140-0008.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0100 Monitoring/Auditing

(1) The director may conduct periodic audits of construction carve-out programs as necessary to ensure compliance with ORS 656.170, 656.172, and these rules.

(2) All records of a construction carve-out program shall be produced upon request of the director.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00.

436-140-0120 Sanctions and Civil Penalties; Rule Violations

(1) The director may assess a civil penalty under ORS 656.745 against an employer, group of employers, or insurer that violates ORS chapter 656, OAR 436-140, or an order of the director.

(2) Any complaint alleging a violation of these rules must be made in writing to the director. The complaint must:

(a) State the grounds for the alleged rule violation;

(b) Include the specific instances of the alleged rule violation;

(c) State the complainant's request for correction and relief; and

(d) Include sufficient documentation to support the complaint.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Amended 12/17/19 as Admin. Order 19-068, eff. 1/1/20

436-140-0130 Service of Orders

(1) An order or notice of the director shall include a notice of the party's appeal rights and shall be served upon the party when the director does any of the following:

(a) notifies an applicant that a program is not approved pursuant to OAR 436-140-0010(4);

(b) suspends or revokes eligibility of a construction carve-out program pursuant to OAR 436-140-0090; or

(c) assesses a civil penalty under the provisions of OAR 436-140-0120.

(2) The director shall serve the order by delivering a copy to the party in the manner provided by Oregon Rules of Civil Procedure 7D(3), or by sending a copy to the party by certified mail with return receipt requested.

Stat. Auth.: ORS 656.726(4), 656.174

Stats. Implemented: ORS 656.170, 656.172, 656.174

Hist.: Adopted 12/11/00 as WCD Admin. Order 00-059, eff. 12/15/00

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 150
WORKERS' BENEFIT FUND CLAIMS PROGRAM

Effective Jan. 1, 2010

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436-150-0001 Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.726(4) and ORS 656.445.

Stat. Auth.: ORS 656.445 and 656.726(4)

Stats. Implemented: ORS 656.445

Hist.: Adopted 12/6/01 as WCD Admin. Order 01-063, eff. 1/1/02

436-150-0002 Purpose

The purpose of these rules is to establish guidelines for regulating, managing, and disbursing moneys in the Workers' Benefit Fund for the purpose of advancing funds to injured workers who have not received payment of compensation due from an insurer in default.

Stat. Auth.: ORS 656.445 and 656.726(4)

Stats. Implemented: ORS 656.445

Hist.: Adopted 12/6/01 as WCD Admin. Order 01-063, eff. 1/1/02

436-150-0003 Applicability of Rules

(1) These rules carry out the provisions of ORS 656.445.

(2) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.445 and 656.726(4)

Stats. Implemented: ORS 656.445

Hist.: Adopted 12/6/01 as WCD Admin. Order 01-063, eff. 1/1/02

436-150-0005 Definitions

As used in OAR 436-150-0001 through 436-150-0040, unless the context requires otherwise:

(1) **"Compensation,"** for the purposes of this program, means temporary and permanent disability due injured workers pursuant to ORS chapter 656, and out-of-pocket expenses for injured workers in accordance with OAR 436-009-0025, such as prescription and mileage reimbursements. Compensation does not include amounts payable to providers, or benefits payable pursuant to claim settlements or claim disposition agreements.

(2) **"Default"** means an insurer has failed to make payments of compensation due injured workers pursuant to ORS chapter 656 for which there is no dispute over the right of the worker to receive such compensation or the amount therein.

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

(4) **"Hearings Division"** means the Hearings Division of the Workers' Compensation Board.

(5) **"Insurer"** means an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in this state.

(6) **"Oregon Insurance Guaranty Association" or "OIGA"** means the association created by ORS 734.550.

(7) **"Paying Agency"** means the insurer, or the insurer's authorized representative, responsible for paying compensation due under ORS chapter 656.

Stat. Auth.: ORS 656.445, 656.726(4)

Stats. Implemented: ORS 656.445

Hist.: Amended 12/1/2009 as WCD Admin. Order 09-062, eff. 1/1/2010

436-150-0006 Administration of Rules

Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and these rules are considered orders of the director.

Stat. Auth.: ORS 656.445 and 656.726(4)

Stats. Implemented: ORS 656.445

Hist.: Adopted 12/6/01 as WCD Admin. Order 01-063, eff. 1/1/02

436-150-0008 Administrative Review

(1) Any party as defined by ORS 656.005, and including the Oregon Insurance Guaranty Association, aggrieved by a proposed order or proposed assessment of civil penalty of the director or division issued pursuant to ORS 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

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

(b) The request for hearing must be filed with the Administrator of the Workers' Compensation Division by the aggrieved person within 60 days after the mailing date of the proposed order or assessment. No hearing will be granted unless the request is mailed or delivered to the administrator within 60 days after the mailing date of the proposed order or assessment.

(2) Under ORS 656.704(2), any party that disagrees with an action or order of the director under these rules, other than as described in section (1) of this rule, may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 656.445, 656.726(4)

Stats. Implemented: ORS 656.445, 656.704, 656.740

Hist.: Amended 10/19/05 as WCD Admin. Order 05-070, eff. 1/2/06

SMC (repeal of ORS 656.750)—ORS 183.335(7), filed and effective 6/18/24

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436-150-0010 Criteria for Eligibility

(1) In order for the director to authorize expenditures from the Workers' Benefit Fund Claims Program there must be:

(a) Verification from an authority from the insurer's state of domicile that the insurer responsible for payment of compensation is in default, such as a notice of voluntary or involuntary rehabilitation, conservatorship, or other information indicating the insurer cannot or will not make payments of compensation; and

(b) An order of the director authorizing disbursements to injured workers from the Workers' Benefit Fund Claims Program. The order shall specify the qualifying claims, duration of payment obligation, and maximum expenditure limitation. The maximum expenditure limitation may not exceed the amount of securities on deposit for the insurer pursuant to ORS 731.628.

(2) When expenditures are authorized pursuant to section (1) of this rule, the paying agency shall provide the director with sufficient information, as specified in OAR 436-150-0030(2), to enable the director to advance funds to eligible injured workers.

(3) To be eligible for payment under the program:

(a) Compensation must be due and payable pursuant to ORS chapter 656; and

(b) There must be a record of an insurance policy on file with the director by the insurer covering the employer on the date of injury.

(4) Payments to eligible injured workers in accordance with these rules shall be applied toward the insurer's payment obligations under ORS chapter 656 and will be deducted from compensation due, pursuant to ORS 734.570.

Stat. Auth.: ORS 656.445, 656.726(4); Stats. Implemented: ORS 656.445
Hist.: Amended 12/1/2009 as WCD Admin. Order 09-062, eff. 1/1/2010

436-150-0020 Limitation of Program

(1) Payment of compensation shall be limited to the amount of securities on deposit for the insurer pursuant to ORS 731.628 and only to the extent the monies are available in the Workers' Benefit Fund.

(2) Payments for individual claims shall be limited to compensation that becomes due and payable during the period of default.

(3) Notwithstanding any other provision of these rules, the director may, in the director's discretion, authorize additional benefits for specific claims in cases of extreme hardship.

(4) In the event of insufficient funds in the Workers' Benefit Fund, the director shall have final authority to determine an equitable distribution, which will proportionately distribute the available funds among the claims having qualified for reimbursement under the Program.

Stat. Auth.: ORS 656.445 and 656.726(4)

Stats. Implemented: ORS 656.445

Hist.: Adopted 12/6/01 as WCD Admin. Order 01-063, eff. 1/1/02

436-150-0030 Payment of Benefits

(1) Payment of compensation may be made by the director after receipt of documentation that compensation is due and payable.

(2) Documentation to support payment from the Workers' Benefit Fund Claims Program shall be submitted by the paying agent to include, but not be limited to:

(a) Insurer name, address, and policy number;

(b) Injured worker name, address, insurer claim number, Workers' Compensation Division claim number, and date of injury;

(c) Employer name and address;

(d) Amount, duration, and purpose of compensation due;

(e) Amounts payable for support pursuant to ORS 656.234, along with supporting documentation; and

(f) Any other information deemed necessary by the director.

Stat. Auth.: ORS 656.445, 656.726(4); Stats. Implemented: ORS 656.445
Hist.: Amended 12/1/2009 as WCD Admin. Order 09-062, eff. 1/1/2010

436-150-0040 Accounting and Repayment of Payment of Benefits

(1) The director shall establish an account of record to monitor all expenditures and transactions relating to the Workers' Benefit Fund Claims Program and these rules. The accounting shall provide a detailed record of payments to each injured worker and the respective insurer responsible for the claim to include, but not be limited to, information as specified in OAR 436-150-0030(2).

(2) When the obligation to make payment of compensation is assumed by the Oregon Insurance Guaranty Association (OIGA) due to the insolvency of an insurer, the OIGA shall reimburse the Workers' Benefit Fund for all moneys advanced to injured workers for covered claims, as specified by OAR 734.510(4) and these rules. The OIGA shall reimburse the director within 60 days of receipt of sufficient information necessary to support the covered claims. All moneys received from the OIGA by the director shall be placed into the Workers' Benefit Fund.

(3) If an insurer defaults in its payments to injured workers, but later resumes its obligation to make payments, the insurer shall reimburse the director for any moneys paid to the injured worker. Such payment shall be in such amounts and at such intervals as prescribed by an order of the director. Failure of the insurer to comply with the order of the director may result in civil penalty pursuant to ORS 656.745.

(4) Any dispute over an amount owing the director in accordance with these rules shall be resolved pursuant to OAR 436-150-0008(2).

Stat. Auth.: ORS 656.445 and 656.726(4)

Stats. Implemented: ORS 656.445

Hist.: Adopted 12/6/01 as WCD Admin. Order 01-063, eff. 1/1/02

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**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 160
ELECTRONIC DATA INTERCHANGE
MEDICAL BILL DATA**

Effective Oct. 1, 2014

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436-160-0001 Authority, Applicability, Purpose, and Administration of these Rules

(1) These rules are promulgated under the director's authority contained in ORS 656.726(4).

(2) These rules apply to workers' compensation related transactions filed with the director by electronic data interchange (EDI) on or after Oct. 1, 2014.

(3) The purpose of these rules is to require workers' compensation medical bill data reporting by electronic data interchange.

(4) Orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 are considered orders of the director.

(5) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Authority: ORS 656.264 and 656.726(4)

Stat. Implemented: ORS ch. 84, 656.264

Hist: Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14

436-160-0004 Adoption of Standards

(1)(a) The director adopts, by reference, IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 2.0, dated Feb 1, 2014.

(b) The director adopts, by reference, the ASC X12 Implementation Acknowledgment for Health Care Insurance (999), dated February 2011.

(2) The form, format, and delivery of data elements reported and definitions will conform to the standards adopted under section (1), unless otherwise provided in these rules.

(3) Copies of the guides in section (1) are available for review during regular business hours at the Workers' Compensation Division, Operations Section, 350 Winter Street NE, Salem OR 97301, 503-947-7717.

(a) IAIABC members may view a copy of the Release 2.0 guide, or non-members may purchase a copy at the IAIABC website: <http://www.iaiaabc.org>.

(b) The ASC X12 999 guide is available for purchase at the X12 online store: <http://store.x12.org/store/healthcare-5010-consolidated-guides>.

Stat. Authority: ORS 656.264; Stat. Implemented: ORS 656.264

Hist: Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14

436-160-0005 General Definitions

For the purpose of these rules, unless it conflicts with statute or rule:

(1) "ANSI" means the American National Standards Institute.

(2) "ASC X12" means the Accredited Standards Committee chartered by the American National Standards Institute (<http://www.x12.org/x12org/index.cfm>).

(3) "Director" means the Director of the Department of Consumer and Business Services or the director's designee for the matter.

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

(5) "Electronic data interchange" or "EDI" means a computer to computer exchange of information in a standardized electronic format.

(6) "Electronic record" means information created, generated, sent, communicated, received, or stored by electronic means.

(7) "Exclude (not applicable to the transaction)" means the data element must not be sent or cannot be sent.

(8) "Fatal Technical" means the transaction set or item structurally requires the data element.

(9) "FEIN" means the federal employer identification number or other federal reporting number used by the insurer, insured, or employer for federal tax reporting purposes.

(10) "Header record" means the record that precedes each transmission for the purpose of identifying a sender, the date and time of the transmission, and the transaction set within the transmission.

(11) "Health Care Provider" has the same meaning as "medical provider," under OAR 436-010-0005(28).

(12) "IAIABC" means the International Association of Industrial Accident Boards and Commissions, a professional trade association comprised of state workers' compensation regulators and insurance representatives (www.iaiaabc.org).

(13) "If Applicable/Available with Item Accept if Invalid" means the data element must be sent if appropriate for the item

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record. Even if the item record has an invalid value, the transaction set or item record will not be rejected.

(14) "If Applicable/Available with Item Reject if Invalid" means the data element must be sent if appropriate for the item record. If the item record has an invalid value, then the transaction set or item record will be rejected.

(15) "Information" means data, text, images, sounds, codes, computer programs, software, databases, or the like.

(16) "Insurer" means the State Accident Insurance Fund Corporation, an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon, an assigned claims agent selected by the director under ORS 656.054, or a self-insured employer.

(17) "Mandatory data element" means an element that will cause a rejection of a transaction if the data element is omitted or submitted in an invalid format, or with an improper value.

(18) "Mandatory Conditional" means the data element is required when certain conditions are present.

(19) "Medical Bill" means a statement of charges for medical services, specified as "compensable medical services," under ORS 656.245.

(20) "Not Applicable" means the data element is not relevant, appropriate, or doesn't apply, although if present with an improper value will not cause a rejection of a transaction.

(21) "Record" means electronic record.

(22) "Trading partner" means the entity sending electronic data interchange (EDI) transactions to the division. Trading partners may include vendors or insurers.

(23) "Trailer record" means the record that designates the end of a transmission and provides a count of transactions contained within the transmission, not including the header and trailer records.

(24) "Transaction" means a set of EDI records, defined according to standards in OAR 436-160-0004.

(25) "Transmission" means a defined set of transactions, including both header and trailer records to be sent to the division or sender by EDI.

Stat. Authority: ORS 656.264 and ORS 656.726(4);

Stat. Implemented: ORS 84.004 and ORS 656.264

Hist: Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

Amended 6/5/14 as WCD AO 14-057, eff. 7/1/14 (temp rule - repealed 7/10/14)

436-160-0040 Recognized Received Date

An electronic record is received when:

(1) The record enters the division's designated information processing system;

(2) All the required data elements and electronic records are in the form and format specified in these rules in the proper sequence; and

(3) The record can be fully processed by the division's information processing system.

Stat. Authority: ORS 656.264 and ORS 656.726(4)

Stat. Implemented: ORS 84.043 and ORS 656.264

Hist: Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

Amended 6/5/14 as WCD Admin. Order 14-057, eff. 7/1/14 (temp rule - repealed 7/10/14)

436-160-0060 Testing Procedures and Requirements

Testing and transition to production:

(1) Before testing can begin, or the division can accept medical billing data, the trading partner must submit a completed Medical Billing Data EDI Trading Partner Profile ([Form 4015](#)) to the division's EDI Coordinator. Form 4015 is available on the division's website: <http://wcd.oregon.gov/insurer/edi/Pages/medical-bill-data.aspx>.

(2) For test purposes each transmission must conform to the standards specified in OAR 436-160-0004.

(3) Test files will be evaluated in terms of whether the data sent was received in the correct standardized format and fully processed by the division's information processing system.

(4) The EDI Coordinator will determine the number of required transactions per test submission based on the anticipated volume of production transactions.

(5) To be approved to send production transmissions, the sender must:

(a) Accomplish secure file transfer protocol (SFTP) uploads and downloads;

(b) Demonstrate the ability to send transmissions to the division that are in the correct format and can be processed through the division's information processing system;

(c) Resolve any consistently recurring errors, and demonstrate the ability to correct and resubmit corrections to errors identified by the division;

(d) Send transmissions to the division that do not result in a 999 acknowledgment indicating a rejection;

(e) Send transmissions to the division without transaction level technical errors;

(f) Demonstrate the ability to receive and process acknowledgement transactions; and

(g) Achieve an acceptance rate of at least 90 percent.

Stat. Authority: ORS 656.726(4);

Stat. Implemented: ORS 84.013 and ORS 656.264

Hist: Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

Amended 6/5/14 as WCD AO 14-057, eff. 7/1/14 (temp rule - repealed 7/10/14)

436-160-0405 Insurers' Reporting Responsibilities

(1) Insurers with an average of at least 100 accepted disabling claims per year, based on the average accepted disabling claim volume for the previous three calendar years, are required to electronically submit detailed medical bill payment data to the Department of Consumer and Business Services under OAR 436-160-0415.

(2) The director will notify an insurer when the insurer has reached a three-year average accepted disabling claim count of at least 100. The insurer is required to report medical bill payment data beginning with the date specified in the notice and must continue to report in subsequent years.

(3) If the insurer's claim count drops below an average of 50 accepted disabling claims, based on the average accepted disabling claim volume for the previous three calendar years,

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insurers may apply to the director for an exemption from the reporting requirement.

(4) The list of insurers required to report medical bill data is published in [Bulletin 359](#).

(5) Insurers that do not meet the requirement to submit medical data under (1) of this rule may voluntarily submit medical billing data.

Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 656.264

Hist: Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14

Amended 6/5/14 as WCD AO 14-057, eff. 7/1/14 (temp rule - repealed 7/10/14)

436-160-0410 Electronic Medical Bill Data Transmission and Format Requirements

(1) The transmission data and format requirements are included in the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 2.0 (Feb 1, 2014), and Appendices A and B of these rules. Oregon-specific information can be found on the division's Electronic Data EDI webpage: <http://wcd.oregon.gov/insurer/edi/Pages/medical-bill-data.aspx>.

(2) Data elements are listed in Appendices A and B:

(a) [Appendix A](#) shows all medical bill data elements accepted by EDI in Oregon, and whether the data element is "Fatal Technical" (F), "Mandatory" (M), "Mandatory Conditional" (MC), "If Applicable/Available with Item Reject if Invalid" (AR), or "If Applicable/Available with Item Accept if Invalid" (AA) for each transaction type.

(b) [Appendix B](#) lists mandatory conditional data elements that are mandatory under specific conditions.

(3) Unless otherwise provided in these rules, the data elements must have the meaning provided in the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 2.0, dated Feb. 1, 2014, Section 2; Health Care Claim (837).

(4) Transactions will be rejected if "Fatal Technical," "Mandatory," or "Mandatory Conditional" data elements are omitted, or include invalid values.

(5) Transactions will be rejected if "If Applicable/Available with Item Reject if Invalid" data elements include invalid values.

(6) Invalid "If Applicable/Available with Item Accept if Invalid" data elements will be ignored if they are included in a transaction.

Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 656.264

Hist: Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14

436-160-0415 Oregon ASC X12 837 Medical Bill Data Reporting Requirements

(1) Event reporting requirements:

(a) Medical bills, including interpreter bills under OAR 436-009, must be reported within 60 days of the date paid.

(b) Denied medical bills for accepted claims must be reported within 60 days of date of denial. Denied bills are defined as any bills in which there is a non-zero charge and a zero payment.

(c) Transactions must be received and accepted by the division within 60 days of either the date paid or the date denied to be considered timely reported. If a transaction is initially rejected it must be corrected, resubmitted, and accepted within the original 60 day time period to be considered timely reported.

(d) Cancellations must be reported as soon as the payer knows that a medical bill was sent in error.

(e) Corrections/Replacements must be reported within 60 days of changes to any of the "Fatal Technical," "Mandatory," or "Mandatory Conditional" data elements in Appendices A and B.

(f) Bills received by the insurer before Oct. 1, 2014, may be reported to the Division using the IAIABC reporting standard version 1.1.

(2) Data reporting requirements are described in Appendices A and B.

(3) Technical requirements are described on the division's Electronic Data EDI webpage for specifications on the Secure File Transfer Protocol (SFTP) requirements.

(4) Data Quality: The director will conduct electronic edits for blank or invalid data. Affected insurers are responsible for pre-screening the data they submit to check that all the required information is reported and is formatted correctly. OAR 436-160-0420 describes the acceptance or rejection protocol for all reported medical bills. The insurer is responsible for timely correcting and resubmitting all rejected transactions for which law or rule require filing, reporting, or notice to the director.

(5) An insurer must request and receive authorization from the director to stop submitting a previously rejected transaction when the division determines the transaction is uncorrectable.

(6) The director will periodically review reported bill data to monitor insurer performance. If the director finds repeated or egregious violations of the reporting requirements of these rules the director may issue civil penalties under OAR 436-160-0445 and ORS 656.745.

(a) Medical bills must be reported timely. "Timely" means that an insurer reports medical bills as required by OAR 436-160-0415(1).

(b) Medical bills must be reported accurately. "Accurately" means that the reported medical bill data accepted by the division conforms to the reporting requirements of the Appendices A and B.

(c) The insurer may be subject to penalties for any reported medical bills that have not been accepted by the division or designated as uncorrectable under OAR 436-160-0415(5) within 180 days of the date of bill payment or denial.

Stat. Authority: ORS 656.726(4)

Stat. Implemented: ORS 656.264

Hist: Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14

436-160-0420 Medical Bill Acknowledgement

(1)(a) The sender is expected to retrieve both TA1 and 999 interchange and functional acknowledgements (as defined by ASC X12) for each medical bill file submitted, unless technical errors in the file prevent 999 processing. In addition, the sender is expected to retrieve the 824 detailed acknowledgement, as

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
ELECTRONIC DATA INTERCHANGE; MEDICAL BILL DATA**

defined by IAIABC Release 2.0 (Feb.1, 2014) for each medical bill file submitted, if at least one transaction has successfully passed the 999 edits.

(b) The detailed acknowledgement will indicate either an item accepted (IA) or an item rejected (IR) acknowledgement for each individual transaction.

(2) A TA1, 999 or 824 acknowledgement will be available for all transactions the division is unable to process, including but not limited to:

(a) An omitted mandatory data element;

(b) An improperly populated data element field, e.g., numeric data element field is populated with alpha or alphanumeric data, or is not a valid value according to the standards adopted in 436-160-0004;

(c) Transactions or electronic records within the transaction that require matching, and cannot be matched to the division's database, e.g., cancellation of an original bill that does not match the Unique Bill ID;

(d) Illogical data in mandatory or required conditional field, e.g., payment date is after reporting date;

(e) Duplicate transmission or duplicate transaction within the transmission;

(f) Invalid bill submission reason code; or

(g) Illogical event sequence relationship between transactions, e.g., cancellation transaction submitted before an original bill is accepted.

(3) A transaction accepted acknowledgement will be available for all transactions that are in a format capable of being processed by the division's information processing system and that are not rejected under section (2) of this rule.

(4) An insurer's obligation to report medical bill data for the purposes of this rule is not satisfied unless the division acknowledges acceptance of the transaction.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Amended 7/10/14 as WCD Admin. Order 14-056, eff. 10/1/14

436-160-0430 Medical Bill Data Changes

(1) Changes to medical bill information must be submitted according to the standards referenced in OAR 436-160-0004.

(2) The Unique Bill ID will be used to match cancellations, corrections, and replacements to the original bill. Failure to match on this data element will result in a rejected transaction.

(3) The insurer must correct and resubmit any transactions rejected for which law or rule requires filing, reporting, or notice to the director.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist: Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD AO 14-057, eff. 7/1/14 (temp rule - repealed 7/10/14)

436-160-0440 Monitoring and Auditing Insurers

(1) The director may monitor and conduct periodic audits of medical bill data to ensure compliance with ORS chapter 656 and these rules.

(2) All records maintained or required to be maintained must be disclosed upon request by the director.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.254, 656.264, 656.455, 656.726
Hist: Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD AO 14-057, eff. 7/1/14 (temp rule - repealed 7/10/14)

436-160-0445 Assessment of Civil Penalties

(1) Under ORS 656.745, the director may assess a civil penalty against an insurer that fails to comply with ORS chapter 656 or the director's rules and orders.

(2) The insurer is responsible for its own actions as well as the actions of others acting on the insurer's behalf. If an insurer or someone acting on the insurer's behalf violates any provisions of these rules, the director may impose a civil penalty against the insurer.

Stat. Authority: ORS 656.726(4)
Stat. Implemented: ORS 656.254, 656.745
Hist: Amended 10/10/13 as WCD Admin. Order 13-057, eff. 7/1/14
Amended 6/5/14 as WCD AO 14-057, eff. 7/1/14 (temp rule - repealed 7/10/14)

Appendix A and Appendix B (OAR 436-160-0410)

Requirement Codes (for Appendix A)	
F	Fatal Technical
M	Mandatory
MC	Mandatory Conditional: Conditions are defined on the Medical Conditions Table, Appendix B
AA	If Applicable/Available with Item Accept if Invalid
AR	If Applicable/Available with Item Reject if Invalid
NA	Not Applicable
X	Exclude (not applicable to the transaction)

Oregon Medical EDI Element Requirement Table - Appendix A

Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
Bill Submission Reason Codes (BSRC)			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Transaction Set Header - Required Loop																		
0532	BHT03	ORIGINATOR TRANSACTION IDENTIFICATION NUMBER	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0100	BHT04	DATE TRANSMISSION SENT	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0101	BHT05	TIME TRANSMISSION SENT	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Loop ID 1000A - Submitter Information - Required Loop																		
0098	NM109	SENDER ID	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Loop ID 1000B - Receiver Information - Required Loop																		
0099	NM109	RECEIVER ID	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Loop ID 2000A - Insurer Hierarchical Level Information - Required Loop																		
0615	DTP03	REPORTING PERIOD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Loop ID 2010AA - Insurer/Self Insured Information - Required Loop																		
0007	NM103	INSURER NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0006	NM109	INSURER FEIN	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0616	N403	INSURER POSTAL CODE	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Loop ID 2010AB - Claim Administrator Information - Situational Loop																		
0188	NM103	CLAIM ADMINISTRATOR NAME	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0187	NM109	CLAIM ADMINISTRATOR FEIN	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0014	N403	CLAIM ADMINISTRATOR MAILING POSTAL CODE	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
Loop ID 2010BA - Employer Information - Required Loop																		
0018	NM103	EMPLOYER NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0016	NM109	EMPLOYER FEIN	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0019	N301	EMPLOYER PHYSICAL PRIMARY ADDRESS	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0020	N302	EMPLOYER PHYSICAL SECONDARY ADDRESS	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0021	N401	EMPLOYER PHYSICAL CITY	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0022	N402	EMPLOYER PHYSICAL STATE CODE	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0023	N403	EMPLOYER PHYSICAL POSTAL CODE	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0164	N404	EMPLOYER PHYSICAL COUNTRY CODE	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA

Oregon Medical EDI Element Requirement Table - Appendix A

Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
Bill Submission Reason Codes (BSRC)			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2000C - Claimant Hierarchical Information - Required Loop																		
0031	DTP03	DATE OF INJURY	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Loop ID 2010CA - Claimant Information - Required Loop																		
0043	NM103	EMPLOYEE LAST NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0044	NM104	EMPLOYEE FIRST NAME	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0045	NM105	EMPLOYEE MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0255	NM107	EMPLOYEE LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0042	NM109	EMPLOYEE SSN	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0153	NM109	EMPLOYEE GREEN CARD	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0154	NM109	EMPLOYEE ID ASSIGNED BY JURISDICTION	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0156	NM109	EMPLOYEE PASSPORT NUMBER	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0152	NM109	EMPLOYEE EMPLOYMENT VISA	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0046	N301	EMPLOYEE MAILING PRIMARY ADDRESS	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0047	N302	EMPLOYEE MAILING SECONDARY ADDRESS	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0048	N401	EMPLOYEE MAILING CITY	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0049	N402	EMPLOYEE MAILING STATE CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0050	N403	EMPLOYEE MAILING POSTAL CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0155	N404	EMPLOYEE MAILING COUNTRY CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0052	DMG02	EMPLOYEE DATE OF BIRTH	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0053	DMG03	EMPLOYEE GENDER CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0015	REF02	CLAIM ADMINISTRATOR CLAIM NUMBER	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0015	REF02	REPLACEMENT CLAIM ADMINISTRATOR CLAIM NUMBER	NA	NA	AA	AA	NA	NA	AA	AA	NA	NA	AA	AA	NA	NA	AA	AA
0005	REF02	JURISDICTION CLAIM NUMBER	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
0051	PER04	EMPLOYEE PHONE NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Oregon Medical EDI Element Requirement Table - Appendix A

Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
Bill Submission Reason Codes (BSRC)																		
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2300 - Bill Information - Required Loop																		
0523	CLM01	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0501	CLM02	TOTAL CHARGE PER BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0502	CLM04	BILLING TYPE CODE	X	NA	X	X	X	NA	X	X	X	NA	X	X	X	NA	X	X
0504	CLM05-1	FACILITY CODE	X	NA	X	X	F	F	F	F	X	NA	X	X	X	NA	X	X
0555	CLM05-1	PLACE OF SERVICE BILL CODE	F	F	F	F	X	X	X	X	F	F	F	F	F	F	F	F
0503	CLM05-2	BILLING FORMAT CODE	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0505	CLM05-3	BILL FREQUENCY TYPE CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0507	CLM16	PROVIDER AGREEMENT CODE*	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0508	CLM19	BILL SUBMISSION REASON CODE	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0511	DTP03	DATE INSURER RECEIVED BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0513	DTP03	ADMISSION DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0622	DTP03	ADMISSION HOUR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0514	DTP03	DISCHARGE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0623	DTP03	DISCHARGE HOUR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0509	DTP03	SERVICE BILL DATE(S) RANGE	NA	NA	NA	NA	M	NA	M	M	NA	NA	NA	NA	NA	NA	NA	NA
0527	DTP03	PRESCRIPTION DATE(s)	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0510	DTP03	DATE OF BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0512	DTP03	DATE INSURER PAID BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0577	CL101	ADMISSION TYPE CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0515	CN101	CONTRACT TYPE CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0516	AMT02	TOTAL AMOUNT PAID PER BILL	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0500	REF02	UNIQUE BILL ID NUMBER	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
0266	REF02	TRANSACTION TRACKING NUMBER	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
0581	REF02	TREATMENT AUTHORIZATION NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0293	REF02	LUMP SUM PAYMENT/SETTLEMENT CODE	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
* Enter "P" if worker is enrolled in a WCD-certified managed care organization (MCO) at time of service or if provider participates in a WCD-registered fee discount agreement. Enter "H" if care was provided through a health maintenance organization (HMO). Enter "Y" for any other agreement. Enter "N" for none.																		

Oregon Medical EDI Element Requirement Table - Appendix A

Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
Bill Submission Reason Codes (BSRC)																		
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
HI Segment - Institutional Bill Principal Diagnosis - Situational Segment																		
0521	HI01-2	PRINCIPAL DIAGNOSIS CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0533	HI01-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
HI Segment - Institutional Bill Admitting Diagnosis - Situational Segment																		
0535	HI01-2	ADMITTING DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
HI Segment - Institutional Bill Other Diagnosis - Situational Segment																		
0522	HI01-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI01-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI02-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI02-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI03-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI03-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI04-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI04-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI05-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI05-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI06-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI06-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI07-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI07-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI08-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI08-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI09-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI09-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI10-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI10-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI11-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI11-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0522	HI12-2	DIAGNOSIS CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0533	HI12-9	PRESENT ON ADMISSION INDICATOR	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X

Oregon Medical EDI Element Requirement Table - Appendix A

Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
Bill Submission Reason Codes (BSRC)																		
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
HI Segment - Outpatient Reason For Visit - Situational Segment																		
0520	HI01-2	OUTPATIENT REASON FOR VISIT CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0520	HI02-2	OUTPATIENT REASON FOR VISIT CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0520	HI03-2	OUTPATIENT REASON FOR VISIT CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
HI Segment - Non-Institutional Diagnosis Codes - Situational Segment																		
0521	HI01-2	PRINCIPAL DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI02-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI03-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI04-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
HI Segment - Non-Institutional Diagnosis Codes - Situational Segment																		
0522	HI05-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI06-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI07-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI08-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI09-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI10-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI11-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0522	HI12-2	DIAGNOSIS CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	MC	NA	MC	MC
HI Segment - Institutional Bill Principal Procedure - Situational Segment																		
0525	HI01-2	PRINCIPAL PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0550	HI01-4	PRINCIPAL PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X

Oregon Medical EDI Element Requirement Table - Appendix A

Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
Bill Submission Reason Codes (BSRC)			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
HI Segment - Institutional Bill Other Procedure Codes - Situational Segment																		
0736	HI01-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI01-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI02-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI02-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI03-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI03-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI04-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI04-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI05-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI05-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI06-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI06-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI07-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI07-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI08-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI08-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI09-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
HI Segment - Institutional Bill Other Procedure Codes - Situational Segment																		
0524	HI09-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI10-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI10-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI11-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI11-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0736	HI12-2	OTHER PROCEDURE CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0524	HI12-4	PROCEDURE DATE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X

Oregon Medical EDI Element Requirement Table - Appendix A

Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
Bill Submission Reason Codes (BSRC)			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
HI Segment - Condition Codes - Situational Segment																		
0556	HI01-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI02-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI03-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI04-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI05-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI06-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI07-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI08-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI09-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI10-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI11-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0556	HI12-2	CONDITION CODE	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
HI Segment - Diagnosis Related Group (DRG) Information - Situational Segment																		
0549	HI01-2	PAID DRG CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0548	HI01-8	BILLED DRG CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
Loop ID 2310A - Billing Provider Information - Required Loop																		
0528	NM103	BILLING PROVIDER LAST/GROUP NAME	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0529	NM104	BILLING PROVIDER FIRST NAME	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0530	NM105	BILLING PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0531	NM107	BILLING PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0634	NM109	BILLING PROVIDER NATIONAL PROVIDER ID	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR

Oregon Medical EDI Element Requirement Table - Appendix A

Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
Bill Submission Reason Codes (BSRC)			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2310A - Billing Provider Information - Required Loop																		
0537	PRV03	BILLING PROVIDER PRIMARY SPECIALTY CODE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0538	N301	BILLING PROVIDER PRIMARY ADDRESS	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0539	N302	BILLING PROVIDER SECONDARY ADDRESS	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0540	N401	BILLING PROVIDER CITY	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0541	N402	BILLING PROVIDER STATE CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0542	N403	BILLING PROVIDER POSTAL CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0569	N404	BILLING PROVIDER COUNTRY CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0629	REF02	BILLING PROVIDER FEIN	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0630	REF02	BILLING PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2310B - Rendering Bill Provider Information - Situational Loop																		
0638	NM103	RENDERING BILL PROVIDER LAST/GROUP NAME	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0639	NM104	RENDERING BILL PROVIDER FIRST NAME	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0640	NM105	RENDERING BILL PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0641	NM107	RENDERING BILL PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0647	NM109	RENDERING BILL PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	M	NA	M	M	MC	NA	MC	MC	MC	NA	MC	MC
0651	PRV03	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
0643	REF02	RENDERING BILL PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2310C - Supervising Provider Information - Situational Loop																		
0658	NM103	SUPERVISING PROVIDER LAST/GROUP NAME	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0659	NM104	SUPERVISING PROVIDER FIRST NAME	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0660	NM105	SUPERVISING PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0661	NM107	SUPERVISING PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0667	NM109	SUPERVISING PROVIDER NATIONAL PROVIDER ID	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0671	PRV03	SUPERVISING PROVIDER PRIMARY SPECIALTY CODE	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0663	REF02	SUPERVISING PROVIDER STATE LICENSE NUMBER	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X

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Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
Bill Submission Reason Codes (BSRC)			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2310D - Service Facility Location Information - Situational Loop																		
0678	NM103	FACILITY NAME	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0682	NM109	FACILITY NATIONAL PROVIDER ID	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0684	N301	FACILITY PRIMARY ADDRESS	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0685	N302	FACILITY SECONDARY ADDRESS	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
0686	N401	FACILITY CITY	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0687	N402	FACILITY STATE CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0688	N403	FACILITY POSTAL CODE	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
0689	N404	FACILITY COUNTRY CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0680	REF02	FACILITY STATE LICENSE NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0683	REF02	FACILITY SERVICE LOCATION ID	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA	AA	NA	AA	AA
Loop ID 2310E - Referring Provider Information - Situational Loop																		
0690	NM103	REFERRING PROVIDER LAST/GROUP NAME	NA	NA	NA	NA	NA	NA	NA	NA	M	NA	M	M	NA	NA	NA	NA
0691	NM104	REFERRING PROVIDER FIRST NAME	NA	NA	NA	NA	NA	NA	NA	NA	MC	NA	MC	MC	NA	NA	NA	NA
0692	NM105	REFERRING PROVIDER MIDDLE NAME/INITIAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0693	NM107	REFERRING PROVIDER LAST NAME SUFFIX	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0699	NM109	REFERRING PROVIDER NATIONAL PROVIDER ID	NA	NA	NA	NA	NA	NA	NA	NA	MC	NA	MC	MC	NA	NA	NA	NA
0695	REF02	REFERRING PROVIDER STATE LICENSE NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	MC	NA	MC	MC	NA	NA	NA	NA
Loop ID 2310F - Managed Care Organization Information - Situational Loop																		
0209	NM103	MANAGED CARE ORGANIZATION NAME	NA MC	NA	NA MC	NA MC	NA MC	NA	NA MC	NA MC	NA MC	NA	NA MC	NA MC	NA MC	NA	NA MC	NA MC
0208	NM109	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0704	REF02	MANAGED CARE ORGANIZATION FEIN	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Oregon Medical EDI Element Requirement Table - Appendix A

Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
Bill Submission Reason Codes (BSRC)			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2320 - Bill Level Adjustments and Amounts - Situational Loop																		
0543	CAS01	BILL ADJUSTMENT GROUP CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0544	CAS02	BILL ADJUSTMENT REASON CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0545	CAS03	BILL ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0546	CAS04	BILL ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0544	CAS05	BILL ADJUSTMENT REASON CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0545	CAS06	BILL ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0546	CAS07	BILL ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0544	CAS08	BILL ADJUSTMENT REASON CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0545	CAS09	BILL ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0546	CAS10	BILL ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0760	AMT02	PRIOR ACTUAL AMOUNT PAID	X	X	X	NA	X	X	X	NA	X	X	X	NA	X	X	X	NA
Loop ID 2400 - Service Line Information - Situational Loop																		
0547	LX01	LINE NUMBER	F	NA	F	F	F	NA	F	F	F	NA	F	F	F	NA	F	F
0714	SV101-2	HCPCS LINE PROCEDURE BILLED CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0715	SV101-2	JURISDICTION PROCEDURE BILLED CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0721	SV101-2	NDC BILLED CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-3	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-3	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-4	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-4	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-5	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-5	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0717	SV101-6	HCPCS MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0718	SV101-6	JURISDICTION MODIFIER BILLED CODE	AA	NA	AA	AA	X	X	X	X	X	X	X	X	X	X	X	X
0551	SV101-7	PROCEDURE DESCRIPTION	NA	NA	NA	NA	X	X	X	X	X	X	X	X	X	X	X	X
0552	SV102	TOTAL CHARGE PER LINE	M	NA	M	M	X	X	X	X	X	X	X	X	X	X	X	X

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Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
Bill Submission Reason Codes (BSRC)			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2400 - Service Line Information - Situational Loop																		
0553	SV103	DAYS(S)/UNIT(S) CODE	M	NA	M	M	X	X	X	X	X	X	X	X	X	X	X	X
0554	SV104	DAY(S) /UNIT(S) BILLED	M	NA	M	M	X	X	X	X	X	X	X	X	X	X	X	X
0600	SV105	PLACE OF SERVICE LINE CODE	AR	NA	AR	AR	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-1	DIAGNOSIS POINTER	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-2	DIAGNOSIS POINTER	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-3	DIAGNOSIS POINTER	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0557	SV107-4	DIAGNOSIS POINTER	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0742	SV121	PROVIDER AGREEMENT LINE CODE	MC	NA	MC	MC	X	X	X	X	X	X	X	X	X	X	X	X
0559	SV201	REVENUE BILLED CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0714	SV202-2	HCPCS LINE PROCEDURE BILLED CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0625	SV202-2	HIPPS RATE CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0715	SV202-2	JURISDICTION PROCEDURE BILLED CODE	X	X	X	X	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0717	SV202-3	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-3	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0717	SV202-4	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-4	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0717	SV202-5	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-5	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0717	SV202-6	HCPCS MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0718	SV202-6	JURISDICTION MODIFIER BILLED CODE	X	X	X	X	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0551	SV202-7	PROCEDURE DESCRIPTION	X	X	X	X	NA	NA	NA	NA	X	X	X	X	X	X	X	X
0552	SV203	TOTAL CHARGE PER LINE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0553	SV204	DAYS(S)/UNIT(S) CODE	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0554	SV205	DAY(S) /UNIT(S) BILLED	X	X	X	X	M	NA	M	M	X	X	X	X	X	X	X	X
0719	SV301-2	ADA PROCEDURE BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0714	SV301-2	HCPCS LINE PROCEDURE BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC

Oregon Medical EDI Element Requirement Table - Appendix A

Type of Medical Bill Record			Professional				Institutional				Pharmaceutical				Dental			
Segment used to report a product or service			SV1				SV2				SV4				SV3			
Bill Submission Reason Codes (BSRC)			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2400 - Service Line Information - Situational Loop																		
0717	SV301-3	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0717	SV301-4	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0717	SV301-5	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0717	SV301-6	HCPCS MODIFIER BILLED CODE	X	X	X	X	X	X	X	X	X	X	X	X	AA	NA	AA	AA
0551	SV301-7	PROCEDURE DESCRIPTION	X	X	X	X	X	X	X	X	X	X	X	X	NA	NA	NA	NA
0552	SV302	TOTAL CHARGE PER LINE	X	X	X	X	X	X	X	X	X	X	X	X	M	NA	M	M
0600	SV303	PLACE OF SERVICE LINE CODE	X	X	X	X	X	X	X	X	X	X	X	X	AR	NA	AR	AR
0742	SV309	PROVIDER AGREEMENT LINE CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0561	SV401	PRESCRIPTION LINE NUMBER	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0721	SV402-2	NDC BILLED CODE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0562	SV405	DISPENSE AS WRITTEN CODE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0563	SV408	DRUG NAME	X	X	X	X	X	X	X	X	NA	NA	NA	NA	X	X	X	X
0762	SV410	COMPOUND DRUG INDICATOR	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0605	DTP03	SERVICE LINE DATE(S) RANGE	M	NA	M	M	M	NA	M	M	M	NA	M	M	M	NA	M	M
0604	DTP03	PRESCRIPTION LINE DATE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0570	QTY02	DRUGS/SUPPLIES QUANTITY DISPENSED	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0571	QTY02	DRUGS/SUPPLIES NUMBER OF DAYS	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0741	CN101	CONTRACT LINE TYPE CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0738	REF02	TREATMENT LINE AUTHORIZATION NUMBER	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0579	AMT02	DRUGS/SUPPLIES DISPENSING FEE	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0572	AMT02	DRUGS/SUPPLIES BILLED AMOUNT	X	X	X	X	X	X	X	X	M	NA	M	M	X	X	X	X
0627	AMT02	LINE ITEM TAX CHARGE AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2420 - Rendering Line Provider Information - Situational Loop																		
0589	NM103	RENDERING LINE PROVIDER LAST/GROUP NAME	AA	NA	AA	AA	NA	NA	NA	NA	AA	NA	AA	AA	AA	NA	AA	AA
0587	NM104	RENDERING LINE PROVIDER FIRST NAME	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
0591	NM105	RENDERING LINE PROVIDER MIDDLE NAME/INITIAL	AA	NA	AA	AA	NA	NA	NA	NA	AA	NA	AA	AA	AA	NA	AA	AA
0588	NM107	RENDERING LINE PROVIDER LAST NAME SUFFIX	AA	NA	AA	AA	NA	NA	NA	NA	AA	NA	AA	AA	AA	NA	AA	AA
0592	NM109	RENDERING LINE PROVIDER NATIONAL PROVIDER ID	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC

Oregon Medical EDI Element Requirement Table - Appendix A

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Segment used to report a product or service			SV1				SV2				SV4				SV3			
			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
Bill Submission Reason Codes (BSRC)																		
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2420 - Rendering Line Provider Information - Situational Loop																		
0595	PRV03	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
0599	REF02	RENDERING LINE PROVIDER STATE LICENSE NUMBER	MC	NA	MC	MC	NA	NA	NA	NA	MC	NA	MC	MC	MC	NA	MC	MC
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop																		
0574	SVD02	TOTAL AMOUNT PAID PER LINE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0722	SVD03-2	ADA PROCEDURE PAID CODE	X	X	X	X	X	X	X	X	X	X	X	X	MC	NA	MC	MC
0726	SVD03-2	HCPCS LINE PROCEDURE PAID CODE	MC	NA	MC	MC	MC	NA	MC	MC	X	X	X	X	MC	NA	MC	MC
0728	SVD03-2	NDC PAID CODE	MC	NA	MC	MC	X	X	X	X	MC	NA	MC	MC	X	X	X	X
0729	SVD03-2	JURISDICTION PROCEDURE PAID CODE	MC	NA	MC	MC	MC	NA	MC	MC	X	X	X	X	X	X	X	X
0727	SVD03-3	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-3	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0727	SVD03-4	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-4	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0727	SVD03-5	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-5	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0727	SVD03-6	HCPCS MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	AR	NA	AR	AR
0730	SVD03-6	JURISDICTION MODIFIER PAID CODE	AR	NA	AR	AR	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0576	SVD04	REVENUE PAID CODE	X	X	X	X	AR	NA	AR	AR	X	X	X	X	X	X	X	X
0580	SVD05	DAYS(S)/UNIT(S) PAID	AA	NA	AA	AA	AA	NA	AA	AA	X	X	X	X	X	X	X	X
0547	SVD06	LINE NUMBER	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0731	CAS01	SERVICE ADJUSTMENT GROUP CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0732	CAS02	SERVICE ADJUSTMENT REASON CODE	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0733	CAS03	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0734	CAS04	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0732	CAS05	SERVICE ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0733	CAS06	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC

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Bill Submission Reason Codes (BSRC)			Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace	Original	Cancellation	Correction	Replace
DN #	Ref. Des.	Data Element Name	00	01	02	05	00	01	02	05	00	01	02	05	00	01	02	05
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop																		
0734	CAS07	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0732	CAS08	SERVICE ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0733	CAS09	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0734	CAS10	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0732	CAS11	SERVICE ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0733	CAS12	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0734	CAS13	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0732	CAS14	SERVICE ADJUSTMENT REASON CODE	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0733	CAS15	SERVICE ADJUSTMENT AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC
0734	CAS16	SERVICE ADJUSTMENT UNITS	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR	AR	NA	AR	AR
0761	AMT02	LINE ITEM PRIOR ACTUAL AMOUNT PAID	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0628	AMT02	LINE ITEM TAX PAID AMOUNT	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC	MC	NA	MC	MC

Oregon Medical EDI Data Element Requirement Conditions - Appendix B

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2010AB - Claim Administrator Information - Situational Loop					
MC	0188	NM103	CLAIM ADMINISTRATOR NAME	Required when the Claim Administrator is a different entity than the insurer or self-insured reported in Loop 2010AA/NM103/DN0007.	Required when NM101 equals "CX".
MC	0187	NM109	CLAIM ADMINISTRATOR FEIN	Required when the Claim Administrator is a different entity than the insurer or self-insured reported in Loop 2010AA/NM103/DN0007.	Required when DN0188 Claim Administrator Name is reported.
MC	0014	N403	CLAIM ADMINISTRATOR MAILING POSTAL CODE	Required when Claim Administrator information is reported in Loop 2010AB	Required when DN0188 Claim Administrator Name is reported.
Loop ID 2010CA - Claimant Information - Required Loop					
MC	0042	NM109	EMPLOYEE SSN	DN0042 Employee SSN is the preferred ID number. If none, see DN153 Employee Green Card. If injured worker has no other identification, use "999999999."	Required when DN0153, DN0154, DN0156 and DN0152 are not reported.
MC	0153	NM109	EMPLOYEE GREEN CARD	Required when DN0042 Employee Social Security number is not available.	Required when DN0042, DN0154, DN0156 and DN0152 are not reported.
MC	0154	NM109	EMPLOYEE ID ASSIGNED BY JURISDICTION	Required when DN0042 Employee Social Security, DN0153 Employee Green Card, DN0152 Employee Employment Visa and DN0156 Employee Passport Number are not available.	Required when DN0042, DN0153, DN0156 and DN0152 are not reported.
MC	0156	NM109	EMPLOYEE PASSPORT NUMBER	Required when DN0042 Employee Social Security, DN0153 Employee Green Card, and DN0152 Employee Employment Visa are not available.	Required when DN0042, DN0153, DN0154 and DN0152 are not reported.
MC	0152	NM109	EMPLOYEE EMPLOYMENT VISA	Required when DN0042 Employee Social Security number and DN0153 Employee Green Card number are not available.	Required when DN0042, DN0153, DN0154 and DN0156 are not reported.
MC	0005	REF02	JURISDICTION CLAIM NUMBER	Required when the insurance carrier, claim administrator, or reporting entity has received the jurisdiction's assigned claim number.	Required when segment is used by jurisdiction and REF01 = Y4.

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2300 - Bill Information - Required Loop					
MC	0513	DTP03	ADMISSION DATE	Required when DN0504 Facility Code is an inpatient type, and either DN0516 Total Amount Paid Per Bill is not equal to 0; or DN0513 is on the bill.	Required when DN0504 Facility Code is one of the following: 11, 12, 18, 21, 22, 28, 41, 65, 66, 86, and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0513 is known.
MC	0514	DTP03	DISCHARGE DATE	Required on final inpatient medical bills.	Required when DN0505 Bill Frequency Type Code equals 1 or 4.
MC	0577	CL101	ADMISSION TYPE CODE	Required when DN0504 Facility Code is an inpatient type, and either DN0516 Total Amount Paid Per Bill is not equal to 0; or DN0577 is on the bill.	Required when DN0504 Facility Code is one of the following: 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89 and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0577 is known.
MC	0515	CN101	CONTRACT TYPE CODE	When DN0549 Paid DRG Code is present, this value must be 01 (DRG). Otherwise, this data element must be reported when the medical services are subject to contractual adjustments and the post-adjudication reimbursement was impacted by the contract, but not be 01.	When DN0549 (Paid DRG Code) is present, this value must be 01 (DRG). Otherwise, this data element must be reported when a contract impacts payment of the bill, but must not have a value of 01.
HI Segment - Institutional Bill Admitting Diagnosis - Situational Segment					
MC	0535	HI01-2	ADMITTING DIAGNOSIS CODE	Required when DN0504 Facility Code is an inpatient type, and either DN0516 Total Amount Paid Per Bill is not equal to 0; or DN0535 is on the bill.	Required when DN0504 Facility Code is one of the following: 11, 12, 18, 21, 22, 28, 41, 65, 66, 84, 86, 89 and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0535 is known.

Oregon Medical EDI Data Element Requirement Conditions - Appendix B

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
HI Segment - Institutional Bill Other Diagnosis					
MC	0522	HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI09-2, HI10-2, HI11-2, HI12-2	DIAGNOSIS CODE	Required when this element is on the bill.	Required when the value of DN0522 is known.
HI Segment - Outpatient Reason For Visit - Situational Segment					
MC	0520	HI01-2	OUTPATIENT REASON FOR VISIT CODE	Required when DN0516 Total Amount Paid Per Bill is not equal to 0, and DN0504 Facility Code is either hospital outpatient, critical access hospital or licensed freestanding emergency medical facility type and DN0577 Admission Type Code describes the admission type as emergency, urgent or trauma and a reported DN0559 Revenue Billed Code equals one of the following values with or without a leading 0: 450, 451, 452, 456, 459, 516, 526, 762.	Required when DN0516 Total Amount Paid Per Bill is not equal to 0, and DN0504 Facility Code equals 13, 85, or 78 and DN0577 Admission Type Code equals 1, 2, or 5 and a reported DN0559 Revenue Billed Code equals one of the following values with or without a leading 0: 450, 451, 452, 456, 459, 516, 526, 762.
MC	0520	HI02-2	OUTPATIENT REASON FOR VISIT CODE	Required when DN0520 (HI01-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.	Required when DN0520 (HI01-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.
MC	0520	HI03-2	OUTPATIENT REASON FOR VISIT CODE	Required when DN0520 (HI02-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.	Required when DN0520 (HI02-2) Outpatient Reason for Visit Code is required and there is another reason for the visit.

Oregon Medical EDI Data Element Requirement Conditions - Appendix B

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
HI Segment - Non-Institutional Diagnosis Codes - Situational Segment					
MC	0521	HI01-2	PRINCIPAL DIAGNOSIS CODE	Required when both DN0537 Billing Provider Primary Specialty Code and DN0651 Rendering Bill Provider Primary Specialty Code are not values excluded from diagnosing an injury or illness, any DN0721 NDC Billed Code or DN0714 HCPCS Line Procedure Billed Code not beginning with A0 is paid as billed, or any DN0728 NDC Paid Code is paid, or any DN0726 HCPCS Line Procedure Paid Code not beginning with A0 is paid; and DN0516 Total Amount Paid Per Bill is not equal to 0.	Required when both DN0537 Billing Provider Primary Specialty Code and DN0651 Rendering Bill Provider Primary Specialty Code are 1) not of the following types (Type Level 1 Provider Type) as defined by Washington Publishing Company: "Respiratory, Developmental, Rehabilitative and Restorative Service Providers," "Technologists, Technicians & Other Technical Service Providers," "Other Service Providers," "Transportation Services" and 2) not any of the classifications (Type Level II Classification) as defined by Washington Publishing Company are named "Ambulance," "Pharmacist," and "Pharmacy;" and any DN0721 NDC Billed Code or DN0714 HCPCS Line Procedure Billed Code not beginning with A0 is paid as billed, or any DN0728 NDC Paid Code is paid, or any DN0726 HCPCS Line Procedure Paid Code is paid; and DN0516 Total Amount Paid Per Bill is not equal to 0.
MC	0522	HI02-2	DIAGNOSIS CODE	Required when DN0521 Principal Diagnosis Code is required and there is another diagnosis.	Required when DN0521 Principal Diagnosis Code is required and there is another diagnosis.
MC	0522	HI03-2	DIAGNOSIS CODE	Required when DN0522 (HI02-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI02-2) Diagnosis Code is required and there is another diagnosis.

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
HI Segment - Non-Institutional Diagnosis Codes - Situational Segment					
MC	0522	HI04-2	DIAGNOSIS CODE	Required when DN0522 (HI03-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI03-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI05-2	DIAGNOSIS CODE	Required when DN0522 (HI04-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI04-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI06-2	DIAGNOSIS CODE	Required when DN0522 (HI05-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI05-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI07-2	DIAGNOSIS CODE	Required when DN0522 (HI06-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI06-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI08-2	DIAGNOSIS CODE	Required when DN0522 (HI07-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI07-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI09-2	DIAGNOSIS CODE	Required when DN0522 (HI08-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI08-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI10-2	DIAGNOSIS CODE	Required when DN0522 (HI09-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI09-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI11-2	DIAGNOSIS CODE	Required when DN0522 (HI10-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI10-2) Diagnosis Code is required and there is another diagnosis.
MC	0522	HI12-2	DIAGNOSIS CODE	Required when DN0522 (HI11-2) Diagnosis Code is required and there is another diagnosis.	Required when DN0522 (HI11-2) Diagnosis Code is required and there is another diagnosis.
HI Segment - Institutional Bill Principal Procedure - Situational Segment					
MC	0550	HI01-4	PRINCIPAL PROCEDURE DATE	Required when DN0525 Principal Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0550 is known.	Required when DN0525 Principal Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0550 is known.

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
HI Segment - Institutional Bill Other Procedure Codes - Situational Segment					
MC	0524	HI01-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI01-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI02-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI02-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI03-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI03-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI04-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI04-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI05-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI05-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI06-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI06-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI07-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI07-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.

Oregon Medical EDI Data Element Requirement Conditions - Appendix B

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
HI Segment - Institutional Bill Other Procedure Codes - Situational Segment					
MC	0524	HI08-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI08-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI09-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI09-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI10-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI10-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI11-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI11-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
MC	0524	HI12-4	PROCEDURE DATE	Required when DN0736 Other Procedure Code is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.	Required when DN0736 Other Procedure Code (HI12-2) is present and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0 or 2) the value of DN0524 is known.
Loop ID 2310A - Billing Provider Information - Required Loop					
MC	0529	NM104	BILLING PROVIDER FIRST NAME	Required when NM102 = 1 (person) and the person has a first name.	Required when NM102 = 1 (person) and the person has a first name.
MC	0569	N404	BILLING PROVIDER COUNTRY CODE	Required when provider address is outside the US.	Required when provider address is outside the US.
MC	0630	REF02	BILLING PROVIDER STATE LICENSE NUMBER	Required when the billing provider does not have a National Provider ID. Use "99999" if the billing provider's type is not licensed by the state (e.g., ambulance or, durable medical equipment).	Required when DN0634 Billing Provider National Provider ID (NM109) is not reported and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0630 is known.

Oregon Medical EDI Data Element Requirement Conditions - Appendix B

Mandatory conditional data elements are normally optional, but become mandatory or expected under conditions established by the jurisdiction. If the defined condition exists, the data element becomes mandatory or expected, and the corresponding rules apply. For Mandatory/Conditional data elements, the data element must be present and must be in a valid format or the transaction will be rejected.

Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2310B - Rendering Bill Provider Information - Situational Loop					
MC	0639	NM104	RENDERING BILL PROVIDER FIRST NAME	Required when NM102 = 1 (person) and the person has a first name.	Required when NM102 = 1 (person) and the person has a first name.
MC	0647	NM109	RENDERING BILL PROVIDER NATIONAL PROVIDER ID	Required when the rendering bill provider has a National Provider ID.	Required when the rendering bill provider has a National Provider ID.
MC	0651	PRV03	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	Required when the rendering bill provider does not have a National Provider ID.	Required when loop 2310B is used and DN0647 Rendering Bill Provider National Provider ID (NM109) is not reported.
MC	0643	REF02	RENDERING BILL PROVIDER STATE LICENSE NUMBER	Required when the rendering bill provider does not have a National Provider ID. Use "99999" if the billing provider's type is not licensed by the state (e.g., ambulance or, durable medical equipment).	Required when loop 2310B is used and DN0647 Rendering Bill Provider National Provider ID (NM109) is not reported.
Loop ID 2310D - Service Facility Location Information - Situational Loop					
MC	0678	NM103	FACILITY NAME	Required when service was performed at an address different from the billing provider's address and either 1) the bill was paid; or 2) the facility name is known.	Required when service was performed at an address different from DN0538 Billing Provider Primary Address and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0678 is known.
MC	0682	NM109	FACILITY NATIONAL PROVIDER ID	Required when service was performed in a facility within the US.	Required when DN0678 Facility Name is present and DN0689 Facility Country Code is not reported, or has a value of US or USA.
MC	0684	N301	FACILITY PRIMARY ADDRESS	Required when service was performed in a facility, (e.g., hospital, ambulatory surgical center, etc.).	Required when DN0678 Facility Name is present.
MC	0686	N401	FACILITY CITY	Required when service was performed in a facility, (e.g., hospital, ambulatory surgical center, etc.).	Required when DN0678 Facility Name is present.
MC	0689	N404	FACILITY COUNTRY CODE	Required when service was performed in a facility outside the US.	Required when DN0678 Facility Name is present and DN0682 Facility National Provider ID is not present.

Oregon Medical EDI Data Element Requirement Conditions - Appendix B

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2310E - Referring Provider Information - Situational Loop					
MC	0691	NM104	REFERRING PROVIDER FIRST NAME	Required when NM102 = 1 (person) and the person has a first name.	Required when NM102 = 1 (person) and the person has a first name.
MC	0699	NM109	REFERRING PROVIDER NATIONAL PROVIDER ID	Required when the referring provider has a National Provider ID.	Required when the referring provider has a National Provider ID.
MC	0695	REF02	REFERRING PROVIDER STATE LICENSE NUMBER	Required when the referring provider does not have a National Provider ID. Use "99999" if the referring provider's type is not licensed by the state (e.g., ambulance or, durable medical equipment).	Required when DN0699 Referring Provider National Provider ID (NM109) is not reported.
Loop ID 2310F - Managed Care Organization Information - Situational Loop					
MC	0209	NM103	MANAGED CARE ORGANIZATION NAME	Required when service was provided under the direction or control of a managed care organization.	Required when service was provided under the direction or control of a managed care organization.
MC	0208	NM109	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	Required when DN507 Provider Agreement Code equals 'P' and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0208 is known.	Required when DN507 Provider Agreement Code equals 'P' and either 1) DN0516 Total Amount Paid Per Bill is not equal to 0; or 2) the value of DN0208 is known.
Loop ID 2320 - Bill Level Adjustments and Amounts - Situational Loop					
MC	0543	CAS01	BILL ADJUSTMENT GROUP CODE	Required when adjustments apply to all service lines on a medical bill containing more than one line.	Required when DN0501 Total Charge Per Bill is not equal to DN0516 Total Amount Paid Per Bill and DN0501 Total Charge Per Bill minus DN0516 Total Amount Paid Per Bill minus the sum of all DN0733 Service Adjustment Amount values is not equal to zero.
MC	0544	CAS02	BILL ADJUSTMENT REASON CODE	Required when adjustments apply to all service lines on a medical bill containing more than one line.	Required when DN0543 Bill Adjustment Group Code is present.
MC	0545	CAS03	BILL ADJUSTMENT AMOUNT	Required when adjustments apply to all service lines on a medical bill containing more than one line.	Required when DN0544 Bill Adjustment Reason Code in CAS02 is present.
MC	0545	CAS06	BILL ADJUSTMENT AMOUNT	Required when a second Bill Adjustment Reason Code applies and is associated with the same group code.	Required when DN0544 Bill Adjustment Reason Code in CAS05 is present.

Oregon Medical EDI Data Element Requirement Conditions - Appendix B

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2320 - Bill Level Adjustments and Amounts - Situational Loop					
MC	0545	CAS09	BILL ADJUSTMENT AMOUNT	Required when a third Bill Adjustment Reason Code applies and is associated with the same group code.	Required when DN0544 Bill Adjustment Reason Code in CAS08 is present.
Loop ID 2400 - Service Line Information - Situational Loop					
MC	0714	SV101-2	HCPCS LINE PROCEDURE BILLED CODE	Required when the bill type is non-pharmaceutical and the service is not billed as any of the following: Oregon-specific service, pharmaceutical product, ADA procedure. The value must be valid when the service was paid using the same code that was billed.	Required when DN0715 Jurisdiction Procedure Billed Code, DN0721 NDC Billed Code, and DN0719 ADA Procedure Billed Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0715	SV101-2	JURISDICTION PROCEDURE BILLED CODE	Required when the bill type is non-pharmaceutical and the service is not billed as any of the following: HCPCS service, pharmaceutical product, ADA procedure. The value must be valid when the service was paid using the same code that was billed.	Required when DN0714 HCPCS Line Procedure Billed Code, DN0721 NDC Billed Code, and DN0719 ADA Procedure Billed Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0721	SV101-2	NDC BILLED CODE	Required when a drug is dispensed by a physician during an office visit. The value must be valid when the service was paid using the same code that was billed.	Required when DN0714 HCPCS Line Procedure Billed Code, DN0715 Jurisdictional Procedure billed Code, and DN0719 ADA Procedure Billed Code are not present. The value must be valid when SVD03-2 is not present and either DN0574 Total Amount Paid Per Line is greater than 0 or DN0574 is not reported.
MC	0557	SV107-1	DIAGNOSIS POINTER	Required when there is a reported diagnosis code and the payment for the service line is greater than 0.	Required when DN0521 Principal Diagnosis Code is reported and either DN0574 Total Amount Paid Per Line is greater than 0 or DN0574 is not reported.

Oregon Medical EDI Data Element Requirement Conditions - Appendix B

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2400 - Service Line Information - Situational Loop					
MC	0557	SV107-2	DIAGNOSIS POINTER	Required when SV107-1 is required and there are two diagnosis pointers for this service line on the bill.	Required when SV107-1 is reported and the value of the second diagnosis pointer is known.
MC	0557	SV107-3	DIAGNOSIS POINTER	Required when SV107-2 is required and there are three diagnosis pointers for this service line on the bill.	Required when SV107-2 is reported and the value of the third diagnosis pointer is known.
MC	0557	SV107-4	DIAGNOSIS POINTER	Required when SV107-3 is required and there are four diagnosis pointers for this service line on the bill.	Required when SV107-3 is reported and the value of the fourth diagnosis pointer is known.
MC	0742	SV121	PROVIDER AGREEMENT LINE CODE	Required when the provider agreement code at the line level is different than the bill level.	Required when the provider agreement code at the line level is different than the bill level.
MC	0714	SV202-2	HCPCS LINE PROCEDURE BILLED CODE	Required when a HCPCS code is used to bill for the service. The value must be valid when the service was paid using the same code that was billed.	The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0625	SV202-2	HIPPS RATE CODE	Required when a HIPPS rate code is used to bill for the service. The value must be valid when the service was paid using the same code that was billed.	The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0715	SV202-2	JURISDICTION PROCEDURE BILLED CODE	Required when an Oregon specific code is used to bill for the service. The value must be valid when the service was paid using the same code that was billed.	The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0719	SV301-2	ADA PROCEDURE BILLED CODE	Required when some amount of the bill is paid, the bill type is dental and the service is not billed as an HCPCS service. The value must be valid when the service was paid using the same code that was billed.	Required when DN0714 HCPCS Line Procedure Billed Code is not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.

Oregon Medical EDI Data Element Requirement Conditions - Appendix B

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2400 - Service Line Information - Situational Loop					
MC	0714	SV301-2	HCPSC LINE PROCEDURE BILLED CODE	Required when the bill type is dental and the service is not billed as an ADA service. The value must be valid when the service was paid using the same code that was billed.	Required when DN0719 ADA Procedure Billed Code is not present. The value must be valid when SVD03-2 is not present and either DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported.
MC	0742	SV309	PROVIDER AGREEMENT LINE CODE	Required when the provider agreement code at the line level is different than the bill level.	Required when the provider agreement code at the line level is different than the bill level.
MC	0741	CN101	CONTRACT LINE TYPE CODE	Required when a contract exists between the payer and the health care provider and the information at the line level is different than the information at the bill level.	Required when a contract exists between the payer and the health care provider and the information at the line level is different than the information at the bill level.
MC	0627	AMT02	LINE ITEM TAX CHARGE AMOUNT	Required when part of the amount charged for this service line includes a tax and the amount of tax is specified on the bill.	Required when part of either DN0552 Total Charge per Line or DN0572 Drugs/Supplies Billed Amount includes a tax and the amount of tax is specified on the bill.
Loop ID 2420 - Rendering Line Provider Information - Situational Loop					
MC	0587	NM104	RENDERING LINE PROVIDER FIRST NAME	Required when NM102 = 1 (person) and reported on the medical bill.	Required when NM102 = 1 (person) and reported on the medical bill.
MC	0592	NM109	RENDERING LINE PROVIDER NATIONAL PROVIDER ID	Required when the rendering line provider has a National Provider ID.	Required when the rendering line provider has a National Provider ID.
MC	0595	PRV03	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	Required when the rendering line provider does not have a National Provider ID.	Required when NM109 DN0592 Rendering Line Provider National Provider ID is not present.
MC	0599	REF02	RENDERING LINE PROVIDER STATE LICENSE NUMBER	Required when the rendering line provider does not have a National Provider ID. Use "99999" if the billing provider's type is not licensed by the state (e.g., ambulance or interpreter).	Required when NM109 DN0592 Rendering Line Provider National Provider ID is not present.

Oregon Medical EDI Data Element Requirement Conditions - Appendix B

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop					
MC	0574	SVD02	TOTAL AMOUNT PAID PER LINE	Required when the amount paid for this service line is not equal to the amount charged.	Required when the amount paid is not equal to which of the following data elements is reported: DN0552 Total Charge per Line or DN0572 Drugs/Supplies Billed Amount.
MC	0722	SVD03-2	ADA PROCEDURE PAID CODE	Required when the service was paid more than \$0.00 using a different code from the billed code and no other paid service code was used.	Required when <ul style="list-style-type: none"> • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.
MC	0726	SVD03-2	HCPCS LINE PROCEDURE PAID CODE	Required when the service was paid more than \$0.00 using a different code from the billed code and no other paid service code was used.	Required when <ul style="list-style-type: none"> • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.
MC	0728	SVD03-2	NDC PAID CODE	Required when the service was paid more than \$0.00 using a different code from the billed code and no other paid service code was used.	Required when <ul style="list-style-type: none"> • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.

Oregon Medical EDI Data Element Requirement Conditions - Appendix B

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop					
MC	0729	SVD03-2	JURISDICTION PROCEDURE PAID CODE	Required when the service was paid more than \$0.00 using a different code from the billed code and no other paid service code was used.	Required when <ul style="list-style-type: none"> • DN0574 TOTAL AMOUNT PAID PER LINE is greater than 0 or DN0574 is not reported and; • the service line was paid using a different service code from the billed service code or the billed service code (including any modifiers) is invalid and; • there are no other paid codes reported in SVD03-2.
MC	0547	SVD06	LINE NUMBER	Required when the payment is bundled with a different service line.	Required when the payment is bundled with a different service line.
MC	0731	CAS01	SERVICE ADJUSTMENT GROUP CODE	Required when line-level adjustments were applied during the adjudication of the medical bill.	For non-pharmaceutical bills (SV4 segment is not used to report the service line), this element is required when DN0545 Bill Adjustment Amount is not reported and DN0552 Total Charge Per Line does not equal DN0574 Total Amount Paid Per Line. For pharmaceutical bills (SV4 segment is used to report the service line), this element is required when DN0545 is not reported and DN0572 Drugs/Supplies Billed Amount does not equal DN0574.
MC	0732	CAS02	SERVICE ADJUSTMENT REASON CODE	Required when line level adjustments were applied during the adjudication of the medical bill.	Required when DN0543 Bill Adjustment Group Code is present.
MC	0733	CAS03	SERVICE ADJUSTMENT AMOUNT	Required when line level adjustments were applied during the adjudication of the medical bill.	Required when DN0544 Bill Adjustment Reason Code in CAS02 is present.
MC	0733	CAS06	SERVICE ADJUSTMENT AMOUNT	Required when it is necessary to report another adjustment beyond what has already been reported for this service line.	Required when DN0544 Bill Adjustment Reason Code in CAS05 is present.

Oregon Medical EDI Data Element Requirement Conditions - Appendix B

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Req Code	DN	Ref. Des.	Data Element Name	Business Condition	Technical Condition
Loop ID 2430 - Service Line Adjustments and Amounts - Situational Loop					
MC	0733	CAS09	SERVICE ADJUSTMENT AMOUNT	Required when it is necessary to report another adjustment beyond what has already been reported for this service line.	Required when DN0544 Bill Adjustment Reason Code in CAS08 is present.
MC	0733	CAS12	SERVICE ADJUSTMENT AMOUNT	Required when it is necessary to report another adjustment beyond what has already been reported for this service line.	Required when DN0544 Bill Adjustment Reason Code in CAS11 is present.
MC	0733	CAS15	SERVICE ADJUSTMENT AMOUNT	Required when it is necessary to report another adjustment beyond what has already been reported for this service line.	Required when DN0544 Bill Adjustment Reason Code in CAS14 is present.
MC	0628	AMT02	LINE ITEM TAX PAID AMOUNT	Required when part of the amount paid for this service line includes a billed tax.	Required when DN0574 Total Amount Paid Per Line is present and DN0627 Line Item Tax Charge Amount is present.

**OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
ELECTRONIC DATA INTERCHANGE; PROOF OF COVERAGE**

**Administrative
Order No.
14-061**

**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 162**

**ELECTRONIC DATA INTERCHANGE;
PROOF OF COVERAGE**

Effective April 1, 2015

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**436-162-0001 Authority, Applicability, Administration,
and Purpose of these Rules**

(1) These rules are promulgated under the director's authority contained in ORS 656.726(4).

(2)(a) These rules apply to workers' compensation proof of coverage transactions filed with the director by electronic data interchange (EDI) on or after April 1, 2015.

(b) For coverage effective before July 1, 2009, the insurer must contact the director if the insurer is unable to file proof of coverage by EDI.

(3) The director's purpose is to require workers' compensation proof of coverage reporting by EDI.

(4) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(5) Orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 are considered orders of the director.

Stat. Auth.: ORS 656.264 and 656.726(4)

Stats. Implemented: ORS ch. 84, 656.017, 656.407, 656.419, 656.423, and 656.427

Hist.: Amended 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0004 Adoption of Standards

(1) The director adopts, by reference, IAIABC EDI Implementation Guide for Proof of Coverage, Release 2.1, dated July 1, 2010.

(2) The form, format, and delivery of data elements reported and definitions will conform to these standards, unless otherwise provided in these rules.

(3) A copy of the Release 2.1 guide is available for review during regular business hours at the Workers' Compensation Division, Operations Section, 350 Winter Street NE, Salem OR 97301, 503-947-7742. IAIABC members may view a copy of the Release 2.1 guide, or non-members may purchase a copy, at the IAIABC website: <http://www.iaiaabc.org>.

Stat. Auth.: ORS 656.264

Stats. Implemented: ORS 656.017, 656.407, 656.419, 656.423, and 656.427

Hist.: Amended 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0005 General Definitions

For the purpose of these rules:

(1) **"Director"** means the director of the Department of Consumer and Business Services or the director's designee for the matter.

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

(3) **"Electronic data interchange"** or **"EDI"** means a computer to computer exchange of information in a standardized electronic format.

(4) **"Electronic record"** means information created, generated, sent, communicated, received, or stored by electronic means.

(5) **"Establishing document"** means a transaction that reports coverage for one or more entities. Establishing document types are coverage notice/binders, new policies, rewrite/reissue transactions, renewals, reinstatements, add jurisdiction endorsements, or add employer/location endorsements.

(6) **"Exclude (X)"** means the data element must not be sent or cannot be sent.

(7) **"Expected (E)"** means the data element is expected on the transaction, but the transaction will be accepted with errors should it fail any edit.

(8) **"Fatal Technical (F)"** means the data element must be sent.

(9) **"Fatal Technical/Conditional (FT)"** means the data element must be sent when certain conditions are present.

(10) **"FEIN"** means the federal employer identification number or other federal reporting number used by the Internal Revenue Service (IRS) to identify a business entity and by the insurer, insured, or employer for federal tax reporting purposes.

(11) **"Header record"** means the record that precedes each transmission for the purpose of identifying a sender, the date and time of the transmission, and the transaction set within the transmission.

(12) **"IAIABC"** means the International Association of Industrial Accident Boards and Commissions, a professional trade association consisting of state workers' compensation

OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
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regulators and insurance and corporate agency representatives (www.iaiaabc.org).

(13) "If Applicable/Available with Item Accept if Invalid (IA)" means the data may or may not be populated. If present, may be edited for valid value or format. The division may or may not return an error on validity edits.

(14) "Industry code" means the code that indicates the nature of the employer's business as published in the North American Industrial Classification System (NAICS) manual, available in print and on CD-ROM from the National Technical Information Service (NTIS) <http://www.ntis.gov/products/naics.aspx>. NAICS codes may also be viewed at the U.S. Census Bureau webpage (<http://www.census.gov/eos/www/naics/>).

(15) "Information" means data, text, images, sounds, codes, computer programs, software, databases, or the like.

(16) "Insurer" means the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon.

(17) "Mandatory (M)" means the data element must be sent. If the data element is omitted or submitted in a format the division is unable to process, the transaction will be rejected.

(18) "Mandatory/Conditional (MC)" means the data element must be sent when certain conditions are present.

(19) "Not Applicable (NA)" means the data element is not required to be sent, but it may be sent. If it is sent, edits may be applied, but unsuccessful edits will not cause the transaction to be rejected.

(20) "Proof of coverage" means an electronic record or set of records identifying an insurer as providing workers' compensation coverage for a specific employer.

(21) "Record" means electronic record.

(22) "Restricted (R)" means the data element value will not be accepted if a stated condition exists.

(23) "Sender" means the vendor or insurer authorized to send EDI transactions to the division.

(24) "Trailer record" means the record that designates the end of a transmission and provides a count of transactions contained within the transmission, not including the header and trailer records.

(25) "Transaction" means a set of EDI records, defined according to standards in OAR 436-162-0004(1).

(26) "Transaction reason code" means the two-digit code identifying the type of transaction and why it was sent (e.g., 54, adding an employer location).

(27) "Transaction set purpose code" means the code identifying whether the transaction is an original, change, or replacement transaction (e.g., 00, original).

(28) "Transaction set type code" means the code identifying the purpose of individual records within the transaction (e.g., 42, canceled by insured).

(29) "Transmission" means a defined set of transactions, including both header and trailer records sent to the division or sender by EDI.

(30) "Triplicate code" means the series of three two-digit codes that define the specific purpose of individual records in a proof of coverage transmission in this order: transaction set purpose code, transaction set type code, and transaction reason code.

(31) "Vendor" means an agent identified by an insurer to submit transmissions to the division on behalf of the insurer.

Stat. Auth.: ORS 656.264 and 656.726(4)
Stats. Implemented: ORS 84.004 and 656.264
Hist.: Amended 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0030 Retention of Electronic Records

Insurers and self-insured employers must retain workers' compensation records under OAR 436-050-0120 and OAR 436-050-0220. Records may be retained in electronic format if the records can be reproduced.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.455 and 731.475
Hist.: Adopted 10/1/10 as Admin. Order 10-058, eff. 1/1/11

436-162-0035 General Filing Information

(1) Senders must follow United States Postal Service guidelines for reporting all addresses.

(2) Transactions will be rejected if Mandatory or Mandatory/Conditional data elements are omitted or submitted in a form or format the division is unable to process.

(3) Not Applicable data element(s) in a transaction will be ignored if the data element is either omitted or submitted in a form or format the division is unable to process.

(4) Worker leasing company (also known in other jurisdictions as professional employer organization) policies will be accepted by EDI, subject to the same data and transaction editing standards as other policies. A policy filing for a worker leasing company does not eliminate the worker leasing company's requirement to file worker leasing notices under OAR 436-180-0110.

(5) Wrap-up policies will be accepted by EDI, subject to the same data and transaction editing standards as other policies. Wrap-up projects and any change of insurer mid-project must be approved by the Oregon Insurance Division.

Stat. Authority: ORS 656.264, 656.419, 656.423, 656.427, 656.726(4)
Stat. Implemented: ORS 656.419, 656.423, 656.427
Hist.: Adopted 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0038 Acknowledgement

(1) The division will respond to submitted transmissions by providing either a Transaction Accepted (TA) or a Transaction Rejected (TR) acknowledgement.

(2) Transaction rejected acknowledgements will be generated for transactions with errors, including but not limited to:

- (a)** An omitted Mandatory data element;
- (b)** An improperly populated data element field, e.g., numeric data element field is populated with alpha or alphanumeric data, or is not a valid value;
- (c)** Transactions or electronic records within the transaction that require matching and cannot be matched to the division's database;

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(d) Illogical data in a Mandatory or Mandatory/Conditional field, e.g., policy expiration date is before policy effective date;

(e) Duplicate transmission or duplicate transaction within the transmission;

(f) Invalid triplicate code; or

(g) Illogical event sequence relationship between transactions, e.g., endorsement transaction submitted before a policy transaction is submitted.

(3) The insurer must correct and resubmit any transactions rejected for which a law or rule requires reporting to the director.

(4) Transactions that are not rejected under section (2) of this rule will result in a Transaction Accepted acknowledgement.

(5) An insurer's obligation to file proof of coverage for the purposes of this rule is not satisfied unless the director acknowledges acceptance of the transaction.

Stat. Authority: ORS 656.264, 656.419, 656.423, 656.427, 656.726(4)

Stat. Implemented: ORS, 656.419, 656.423, 656.427

Hist: Amended & renum. from 436-162-0320 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0040 Recognized Filing Date

(1) An electronic record is considered filed on the date it is delivered to the director only if the division issues a Transaction Accepted acknowledgement.

(2) Rejected transactions are not considered filed and do not satisfy proof of coverage requirements until they are corrected, resubmitted, and accepted by the division.

Stat. Auth.: ORS 656.264 and 656.726(4)

Stats. Implemented: ORS 84.043 and 656.264

Hist.: Amended 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0310 Electronic Filing Requirements

(1) Unless otherwise provided in these rules, insurers must transmit proof of coverage by EDI, and either use an approved vendor, or be approved as a sender.

(2) Unless otherwise provided in these rules, the data elements have the meaning provided in the data dictionary of the IAIABC EDI Implementation Guide for Proof of Coverage, Release 2.1, dated July 1, 2010, referenced in OAR 436-162-0004(1).

(3) Data elements are listed in Appendices A and B:

(a) Appendix A shows all proof of coverage data elements accepted by EDI in Oregon, and whether the data element is Exclude (X), Expected (E), Fatal Technical (F), Fatal Technical/Conditional (FT), Mandatory (M), Mandatory/Conditional (MC), Not Applicable (NA), or Restricted (R), for each transaction type.

(b) Appendix B lists Mandatory/Conditional data elements and the applicable conditions that make the data element mandatory.

(4) Filing due dates are listed in Appendix C, the Event Table.

(5) An insurer may file proof of coverage EDI by:

(a) Transmitting an electronic record of the proof of coverage data elements identified as Mandatory or Mandatory/Conditional, including a correct FEIN, as defined in

OAR 436-162-0005(10), for each legally distinct employer included in the establishing document transaction; and

(b) Transmitting an establishing document transaction, coverage notice/binder, new/renew policy, rewrite/reissue policy, reinstatement, add location, add employer, or add jurisdiction.

(6) If an employer elects to include any nonsubject worker(s) for coverage, or subsequently to exclude such workers from coverage, the insurer must submit a transaction with a reason code for including or excluding a corporate officer, partner, member, sole proprietor, or any other nonsubject worker as described in ORS 656.027.

(7) Insurers may not:

(a) Submit placeholder or invalid FEINs; or

(b) Submit paper documents to the director without the director's express permission.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.264

Hist.: Amended 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0335 Testing Procedures and Transaction Accuracy Standards

(1) An insurer that wants to self report proof of coverage must report through an approved vendor until the insurer completes all of the testing requirements in this rule and receives approval from the director to self report.

(2) To obtain approval, each sender must successfully complete the Secure File Transfer Protocol (SFTP) test, demonstrate ability to successfully transmit coverage data in the format specified in OAR 436-162-0004(1), achieve ninety percent reporting accuracy, and retrieve and process automated EDI acknowledgements.

(3) To begin the testing process for proof of coverage EDI, the sender must:

(a) Contact the division's EDI coordinator. Contact information is on the division's webpage:

<http://wcd.oregon.gov/insurer/edi/Pages/proof-of-coverage.aspx>; and

(b) Complete and submit the proof of coverage EDI transmission profile ([Form 440-4979](#)), available from: <http://wcd.oregon.gov/insurer/edi/Pages/proof-of-coverage.aspx>.

(4) A successful EDI test is determined by the following:

(a) The resolution of any consistently recurring Fatal Technical errors identified by the division;

(b) Transmissions are sent to the division without errors in the header or trailer record;

(c) Transmissions are sent to the division without transaction level technical errors; and

(d) The sender is able to retrieve and process the automated EDI acknowledgement transactions.

(5) To move from testing to production:

(a) The sender must submit a minimum of three transmissions containing at least three records for each Oregon valid triplicate code included in Appendix A.

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(b) Data transmitted during the proof of coverage EDI test must represent actual proof of coverage data, which will be discarded after the test.

(c) The division will provide the sender with an acknowledgement file to account for the processing outcome of each transaction, i.e., accepted or rejected. The sender should reconcile or correct identified data errors in their source data system as necessary.

(d) Ninety percent of transactions submitted during the testing phase must be accepted by the division. Additional proof of coverage EDI test transmission(s) may be required until a ninety percent accuracy rate is achieved.

(6) The director will notify senders once they have successfully completed testing.

(7) Once approved, the sender must maintain the accuracy as defined in sections (4) and (5)(d) of this rule. Failure to meet technical requirements may result in the revocation of EDI transmission approval.

(8) The division will inform the sender and insurer (if different) if accuracy standards for technical requirements fall below standards prescribed in sections (2) and (5)(d) of this rule.

Stat. Authority: ORS 656.264, 656.419, 656.423, 656.427, 656.726(4)

Stat. Implemented: ORS 656.264, 656.419, 656.423, 656.427

Hist: Amended & renum. from 436-162-0060 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0340 Changes or Corrections

(1) Changes or corrections to proof of coverage information must be submitted under the standards referenced in OAR 436-162-0004(1).

(2) To report changes or corrections of an insured employer's name or address, or other data elements, the insurer must transmit the appropriate transaction to specify what data is being changed or corrected.

(3) The insurer's policy number is used to assist in matching each transaction to the appropriate employer. When an insurer changes a policy number, the insurer must report that change prior to the next transaction submitted for that policy. Failure to report a change in the policy number will prevent future filings from being processed by the division's information processing system and the insurer will receive a Transaction Rejected acknowledgement.

(4) To add or delete coverage for corporate officers, members of a limited liability company, partners, sole proprietors, or other nonsubject workers, the insurer must file the appropriate "include" or "exclude" endorsement transaction to the associated policy filing.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.264 and 656.419

Hist.: Amended 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0370 Proof of Coverage Terminations

When the insurer cancels coverage before the expiration of the policy term, the insurer must:

(1) Provide written notice to the employer under ORS 656.427(1) and (3);

(2) Retain a record of the written notice sent to the employer under ORS 656.427, and proof of mailing of that notice, for inspection by the division; and

(3) Provide notice to the director under ORS 656.427 by EDI.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.264, 656.419, 656.423 and 656.427

Hist: Amended 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0380 Cancellation of Coverage by the Employer

When the employer cancels coverage before the expiration of the policy term, the insurer must:

(1) Retain a record of the written or verbal notice provided by the employer to the insurer under ORS 656.423, including proof of date of receipt of that notice, for inspection by the division; and

(2) Provide notice to the director under ORS 656.423 by EDI.

Stat. Authority: ORS 656.264, 656.423, 656.726(4); Stat. Implemented: ORS 656.423

Hist: Adopted 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0400 Monitoring and Auditing Insurers

(1) The director may monitor and conduct periodic audits of proof of coverage reporting data to ensure compliance with ORS chapter 656 and these rules. If the director finds violations of the reporting requirements of these rules the director may issue civil penalties under OAR 436-162-0440 and ORS 656.745.

(a) Proof of coverage must be reported timely. "Timely" means that an insurer reports data within the time allowed by these rules, including Appendix C, the Event Table.

(b) Proof of coverage must be reported accurately. "Accurately" means that the reported coverage data accepted by the division conforms to the reporting requirements of these rules, including Appendices A, B, and C.

(2) All records maintained or required to be maintained must be disclosed upon request by the director.

Stat. Authority: ORS 656.264, 656.726(4), 656.745

Stat. Implemented: ORS 656.419, 656.423, 656.427

Hist: Adopted 11/13/14 as Admin. Order14-061, eff. 4/1/15

436-162-0440 Assessment of Civil Penalties

(1) Under ORS 656.745, the director may assess a civil penalty against an insurer that fails to comply with ORS chapter 656 or the director's rules and orders.

(2) The insurer is responsible for its own actions as well as the actions of others acting on the insurer's behalf. If an insurer or someone acting on the insurer's behalf violates any provisions of these rules, the director may impose a civil penalty against the insurer.

Stat. Authority: ORS 656.264, 656.726(4), 656.745

Stat. Implemented: ORS 656.419, 656.423, 656.427

Hist: Adopted 11/13/14 as Admin. Order14-061, eff. 4/1/15

[Appendix A, B, and C \(OAR 436-162-0310\)](#) [link to tables]

If the above link does not connect you to the electronic data interchange webpage, please copy and paste the following link into your browser's URL window:

<http://wcd.oregon.gov/insurer/edi/Pages/proof-of-coverage.aspx>

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 170
INDEPENDENT CONTRACTORS

Effective Feb. 1, 2007

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436-170-0002 Purpose of Rule

The Landscape Contractors Board, Department of Revenue, Department of Consumer and Business Services, Employment Department, and Construction Contractors Board must adopt rules together to carry out ORS 670.600. ORS 670.600 defines "independent contractor" for purposes of the programs administered by these agencies. This rule is intended to ensure that all five agencies apply and interpret ORS 670.600 in a consistent manner; to clarify the meaning of terms used in ORS 670.600; and, to the extent possible, to enable interested persons to understand how all five agencies will apply ORS 670.600.

Stat. Auth: ORS 656.726(4); 670.605
Stats. Implemented: ORS 316.162; 670.600
Hist.: Adopted 1/30/07 as WCD Admin. Order 07-050, eff. 2/1/07

436-170-0100 Statutory Context

(1) ORS 670.600 generally establishes three requirements for "independent contractors." One requirement is that an "independent contractor" must be engaged in an "independently established business." Another requirement is related to licenses and certificates that are required for an "independent contractor" to provide services. A third requirement is that an "independent contractor" must be "free from direction and control over the means and manner" of providing services to others.

(2) The specific focus of this rule is the "direction and control" requirement. See ORS 670.600 for the requirements of the "independently established business" test and for licensing and certification requirements.

Stat. Auth: ORS 656.726(4); 670.605
Stats. Implemented: ORS 316.162; 670.600
Hist.: Adopted 1/30/07 as WCD Admin. Order 07-050, eff. 2/1/07

436-170-0200 Direction and Control Test

(1) ORS 670.600 states that an "independent contractor" must be "free from direction and control over the means and manner" of providing services to others. The agencies that have adopted this rule will use the following definitions in their interpretation and application of the "direction and control" test:

(a) **"Means"** are resources used or needed in performing services. To be free from direction and control over the means

of providing services an independent contractor must determine which resources to use in order to perform the work, and how to use those resources. Depending upon the nature of the business, examples of the "means" used in performing services include such things as tools or equipment, labor, devices, plans, materials, licenses, property, work location, and assets, among other things.

(b) **"Manner"** is the method by which services are performed. To be free from direction and control over the manner of providing services an independent contractor must determine how to perform the work. Depending upon the nature of the business, examples of the "manner" by which services are performed include such things as work schedules, and work processes and procedures, among other things.

(c) **"Free from direction and control"** means that the independent contractor is free from the right of another person to control the means or manner by which the independent contractor provides services. If the person for whom services are provided has the right to control the means or manner of providing the services, it does not matter whether that person actually exercises the right of control.

(2) Right to specify results to be achieved. Specifying the final desired results of the contractor's services does not constitute direction and control over the means or manner of providing those services.

Stat. Auth: ORS 656.726(4); 670.605
Stats. Implemented: ORS 316.162; 670.600
Hist.: Adopted 1/30/07 as WCD Admin. Order 07-050, eff. 2/1/07

436-170-0300 Application of "direction and control" test in construction and landscape industries

(1) The provisions of this section apply to:

(a) Architects licensed under ORS 671.010 to 671.220;

(b) Landscape architects licensed under ORS 671.310 to 671.479;

(c) Landscaping businesses licensed under ORS 671.510 to 671.710;

(d) Engineers licensed under ORS 672.002 to 672.325; and

(e) Construction contractors licensed under ORS chapter 701.

(2) A licensee described in section (1) that is paying for the services of a subcontractor in connection with a construction or landscape project, will not be considered to be exercising direction or control over the means or manner by which the subcontractor is performing work when the following circumstances apply:

(a) The licensee specifies the desired results of the subcontractor's services by providing plans, drawings, or specifications that are necessary for the project to be completed.

(b) The licensee specifies the desired results of the subcontractor's services by specifying the materials, appliances or plants by type, size, color, quality, manufacturer, grower, or price, which materials, appliances or plants are necessary for the project to be completed.

(c) When specified by the licensee's customer or in a general contract, plans, or drawings and in order to specify the desired

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results of the subcontractor's services, the licensee provides materials, appliances, or plants, including, but not limited to, roofing materials, framing materials, finishing materials, stoves, ovens, refrigerators, dishwashers, air conditioning units, heating units, sod and seed for lawns, shrubs, vines, trees, or nursery stock, which are to be installed by subcontractors in the performance of their work, and which are necessary for the project to be completed.

(d) The licensee provides, but does not require the use of, equipment (such as scaffolding or fork lifts) at the job site, which equipment is available for use on that job site only, by all or a significant number of subcontractors requiring such equipment.

(e) The licensee has the right to determine, or does determine, in what sequence subcontractors will work on a project, the total amount of time available for performing the work, or the start or end dates for subcontractors working on a project.

(f) The licensee reserves the right to change, or does change, in what sequence subcontractors will work on a project, the total amount of time available for performing the work, or the start or end dates for subcontractors working on a project.

Stat. Auth: ORS 656.726(4); 670.605

Stats. Implemented: ORS 316.162; 670.600

Hist.: Adopted 1/30/07 as WCD Admin. Order 07-050, eff. 2/1/07

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 180

WORKER LEASING

Effective July 1, 2018

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436-180-0003 Administration of Rules [Formerly 436-050-0003]

(1) Purpose.

These rules carry out the provisions of ORS 656.403(4); 656.850; and 656.855 related to worker leasing companies.

(2) Director's discretion.

The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Statutory authority: ORS 656.726(4) and 656.855

Statutes implemented: ORS 656.403(4); 656.850 and 656.855

Hist: Adopted 6/7/18 as WCD Admin. Order 18-057, effective 7/1/18

436-180-0005 Definitions [Formerly 436-050-0005]

Unless a term is defined elsewhere in these rules, the definitions of ORS 656.005 and 656.850 are incorporated by reference and made a part of these rules. For the purpose of these rules, unless the context requires otherwise:

(1) **"Board"** means the Workers' Compensation Board and includes its Hearings Division.

(2) **"Client"** means a person to whom workers are provided under contract and for a fee on a temporary or leased basis. "Client" does not include a person that shares common majority

ownership with the person providing workers under contract and for a fee.

(3) **"Common majority ownership"** means the same person or group of persons owns more than 50 percent of each entity. If an entity owns a majority interest in another entity, which in turn owns a majority interest in another entity, all entities so related are considered to share common majority interest.

(4) **"Controlling person"** means:

(a) A person who holds an ownership interest greater than or equal to the lesser of:

(A) The average ownership interest of all owners; or

(B) 10 percent;

(b) A person who is an officer or director of a corporation; a member or manager of a limited liability company; a partner of a partnership; or

(c) An individual who has the power to direct or cause the direction of the management, policies, or operation of a worker leasing company.

(5) **"Coverage"** means assurance that subject workers and their beneficiaries will receive compensation for compensable injuries as provided for under ORS chapter 656 through a workers' compensation insurance policy or by a self-insured employer.

(6) **"Days"** means calendar days unless otherwise specified.

(7) **"Director"** means the director of the Department of Consumer and Business Services or the director's designee.

(8) **"Federal Employer Identification Number"** or **"FEIN"** means the reporting number used by the Internal Revenue Service to identify a business entity for federal tax reporting purposes. "FEIN" does not include a Social Security Number or other reporting number used to identify an individual.

(9) **"Leased worker"** means any worker provided by a worker leasing company to a client on other than a temporary basis, as described in OAR 436-180-0120.

(10) **"License"** means an Oregon worker leasing license issued by the department under ORS 656.855.

(11) **"Person"** means an individual, partnership, corporation, joint venture, limited liability company, association, government agency, sole proprietorship, or other business entity allowed to do business in Oregon.

(12) **"Proof of coverage"** has the same meaning as in OAR 436-162-0005.

(13) **"Worker leasing company"** means a person that provides workers to a client, by contract and for a fee, but does not include a person that provides workers to a client on a temporary basis, as described under OAR 436-180-0120. For the purposes of these rules, a professional employer organization (PEO) is a worker leasing company.

(14) **"Worker leasing contract"** means the written agreement between a worker leasing company and a client that establishes the rights, duties, and obligations of each with respect to leased workers. For the purposes of these rules, the effective date of a

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worker leasing contract is the first date an Oregon subject worker begins work for a client under the contract.

(15) "Written" means information communicated in writing, and includes electronic records.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.726(4)

Hist: Adopted 6/7/18 as WCD Admin. Order 18-057, effective 7/1/18

436-180-0008 Requests for Hearings or Administrative Review [Formerly 436-050-0008]

(1) Request for hearing on proposed sanctions or civil penalties.

Any person that disagrees with a proposed order or assessment of a civil penalty under ORS 656.735, or 656.745 may request a hearing by the board. To request a hearing, the person must:

(a) Mail or deliver a written request to the Workers' Compensation Division within 60 days of the mailing date of the proposed order or assessment; and

(b) Specify, in the request, the reasons why the person disagrees with the proposed order or assessment.

(2) Request for hearing on an action or order of the director.

Any person that disagrees with an action or order of the director under these rules other than as described in section (1) of this rule may request a hearing under OAR 436-001-0019, subject to the following:

(a) The request for hearing must be made in writing and must be filed:

(A) Within 60 days of the mailing date of an order denying an application for initial or renewal license;

(B) Within 90 days of an emergency suspension order suspending a license under OAR 436-180-0160(3); or

(C) Within 30 days of the mailing date of any other order or notice of action; and

(b) OAR 436-001 applies to the hearing.

Statutory authority: ORS 656.704 and 656.726(4)

Statutes implemented: ORS 656.704 and 656.745

Hist: Adopted 6/7/18 as WCD Admin. Order 18-057, effective 7/1/18

SMC (repeal of ORS 656.750)— ORS 183.335(7), filed and effective 6/18/24

436-180-0100 Responsibility for Providing Coverage under a Lease Arrangement [Formerly 436-180-0400]

(1) General.

Every worker leasing company providing workers to a client must satisfy the requirements of ORS 656.017 and 656.407.

(2) When the worker leasing company must provide coverage.

Except when the client provides coverage as described in section (3) of this rule, when a worker leasing company provides workers to a client, the worker leasing company must provide coverage for the leased workers and any subject workers employed by the client.

(3) When the client provides coverage.

When during the term of the worker leasing contract, the director has proof of coverage for a client-purchased policy on file, or when the client is a self-insured employer:

(a) The client's coverage extends to the leased workers and any subject workers employed by the client; and

(b) The client will be considered a noncomplying employer if it allows its coverage to terminate and continues to lease or employ any subject workers, unless the client obtains new coverage or the worker leasing company has notified the director that it provides coverage for the client under OAR 436-180-0110(1).

(4) Leasing from more than one worker leasing company.

A client may not lease workers from more than one worker leasing company at a time unless the client provides coverage as described under section (3) of this rule.

(5) Providing coverage to another worker leasing company.

A worker leasing company may not provide coverage for another worker leasing company doing business in Oregon or any other state. This section does not apply when:

(a) Two or more worker leasing companies that share common majority ownership are included as named insureds on a single policy; and

(b) Each worker leasing company separately meets the requirements of ORS 737.270(4).

(6) Leasing from unlicensed worker leasing company.

No person may obtain workers by contract and for a fee on a non-temporary basis from an unlicensed worker leasing company.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.850

Hist: Adopted 6/7/18 as WCD Admin. Order 18-057, effective 7/1/18

436-180-0110 Notice of Client Coverage; Changes to Coverage Information; Termination; Reinstatements [Formerly 436-050-0410]

(1) Notice of client coverage.

When a worker leasing company provides coverage to a client under OAR 436-180-0100(2), the worker leasing company must file written notice with the director and its insurer, using [Form 2465](#), "Worker Leasing Notice," subject to the following:

(a) The Form 2465 must be filed within 30 days after the effective date of the worker leasing contract; and

(b) The Form 2465 must be correct, complete, signed by an authorized representative of the worker leasing company, and must include:

(A) The client's:

(i) Legal name and assumed business names, if any;

(ii) FEIN;

(iii) Type of ownership;

(iv) North American Industry Classification System Code;

(v) Governing class code or National Council on Compensation Insurance (NCCI) code;

(vi) Phone number, email address, and mailing address; and

(vii) Street address of Oregon location; and

(B) The worker leasing company's:

(i) Legal name and assumed business names, if any;

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- (ii) FEIN;
- (iii) Oregon worker leasing license number;
- (iv) Effective date of Oregon client coverage; and
- (v) Contact name and phone number.

(2) Changes or corrections to client coverage information.

A worker leasing company must notify the director and its insurer of changes or corrections to information provided under section (1) of this rule using [Form 3270](#), "Worker Leasing Update Notice," within 30 days after the effective date of a change, or knowledge a correction is needed.

(3) Termination of client coverage.

A worker leasing company may terminate its obligation to provide coverage to a client by providing written notice of the termination, subject to the following:

(a) The worker leasing company may use [Form 3271](#), "Worker Leasing Termination Notice," to satisfy the requirements of this section;

(b) The notice must state:

(A) The requested effective date of the termination;

(B) The reason for the termination;

(C) The client's:

(i) Legal name and assumed business names, if any;

(ii) FEIN;

(iii) Phone number, email address, and mailing address; and

(D) The name, phone number, and signature of an authorized representative of the worker leasing company;

(c) The notice must be sent to the client's last-known address by U.S. mail, and copied to the worker leasing company's insurer and the director;

(d) The notice must be sent within 30 days after the final date of the lease arrangement, or knowledge that the client obtained other coverage;

(e) Regardless of the requested effective date stated under paragraph (3)(b)(A), termination of the worker leasing company's obligation to provide coverage to the client will not be effective until at least:

(A) The 30th day after the notice is received by the director; or

(B) The effective date of other coverage for the client that has been filed with the director.

(4) Reinstatement of client coverage.

When a worker leasing company reinstates coverage to a client following a termination under section (3) of this rule, the worker leasing company must notify the director using [Form 5361](#), "Worker Leasing Reinstatement Notice," subject to the following:

(a) The Form 5361 must be filed within 30 days after the reinstatement becomes necessary; and

(b) The Form 5361 must be correct, complete, signed by an authorized representative of the worker leasing company, and must include:

(A) The client's:

(i) Legal name and assumed business names, if any;

(ii) FEIN;

(iii) Phone number, and

(iv) Email address, if known;

(B) The worker leasing company's:

(i) Legal name and assumed business names, if any;

(ii) FEIN;

(iii) Oregon worker leasing license number; and

(iv) Contact name and phone number.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.850

Hist: Adopted 6/7/18 as WCD Admin. Order 18-057, effective 7/1/18

436-180-0120 Temporary Worker Distinguished from Leased Worker [Formerly 436-050-0420]

(1) Temporary service providers.

A person that provides a worker to a client by contract and for a fee will be considered a temporary service provider if the worker is provided on a temporary basis, subject to the following:

(a) **"Temporary basis"** means the worker was provided to supplement a client's regular workforce for a special situation, as a student worker, or as a probationary hire as described under ORS 656.850(1)(b). The worker will be considered to be provided on a temporary basis if there is contemporaneous written documentation of the placement;

(b) **"Contemporaneous written documentation"** means documents that are created at the time the temporary service provider and client make the arrangements for placement of the worker. The documents must indicate the expected duration of the placement, and:

(A) If the worker was provided to supplement a client's regular workforce for a special situation, the documentation must describe the special situation. A special situation includes, but is not limited to:

(i) An employee absence or leave, from which the employee is expected to return;

(ii) A shortage in skilled professional staff, whether licensed or not, for a known duration of time. Supporting documentation may include license information, and must establish whether the worker is provided to supplement or to satisfy a client's need for the skill;

(iii) A seasonal or sporadic increase in workload that requires assistance in addition to the client's regular workforce. Documentation must establish the nature of the increase in workload; or

(iv) A special assignment or project outside of the routine activities of the client's business, where the worker will be terminated or assigned to another temporary project upon completion. Documentation must describe the project and how it is outside of the routine activities of the client's business;

(B) If the worker is provided and paid through a work experience program, the name of the school or institution and the work experience program; or

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(C) If the worker is provided as a probationary new hire and the worker has a reasonable expectation of transitioning to permanent employment with the client, evidence that the client established a probationary period in its overall employment selection program before obtaining workers from the person. Evidence may include copies of the client's written program, or a written agreement between the temporary service provider and the client establishing the probationary period before workers were provided; and

(c) Either the person providing the worker or the client must provide the contemporaneous written documentation to the director upon request. If a person fails to provide the contemporaneous written documentation, the director will investigate to determine if the worker was provided on a temporary basis. If the director determines that the worker was provided on other than a temporary basis, the person will be considered a worker leasing company.

(2) Persons providing leased and temporary workers.

If a person providing workers on both a leased and temporary basis does not maintain the records required under OAR 436-180-0150(2), all workers will be considered to be leased workers.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.850

Hist: Adopted 6/7/18 as WCD Admin. Order 18-057, effective 7/1/18

436-180-0140 Qualifications, Applications, and Renewals for License as a Worker Leasing Company [Formerly 436-050-0440]

(1) Prohibition against leasing workers without a license.

No person may perform services as a worker leasing company in Oregon without a valid license.

(2) Qualification for license.

To qualify for an initial license or renewal, a person must:

(a) Be registered and authorized to do business in Oregon under ORS chapter 58, 60, 62, 63, 65, 67, 70, or 648, as applicable, or be a municipal or public corporation as defined in ORS 297.405;

(b) Maintain coverage under ORS 656.017;

(c) Submit a complete application under this rule and be approved for licensure; and

(d) Upon approval, pay the required licensing fee of \$2,050.

(3) Application for full leasing license.

Except as described in section (4) of this rule, each applicant for an initial license must submit [Form 2466](#), "Worker Leasing License Application." The form and accompanying documentation must include:

(a) Complete information for the applicant, including:

(A) Legal and assumed business names;

(B) Mailing address;

(C) Phone number;

(D) FEIN;

(E) Physical address of the principal place of business;

(F) Names and contact information, including a phone number and valid email address, for at least two representatives who are authorized to respond to inquiries about licensing, leasing, and coverage;

(G) A disclosure of all states where the applicant operates as a worker leasing company, including identification numbers and expiration dates of any licenses, registrations, recognitions, or certifications and disclosure of any that are not in good standing;

(H) Signed releases for verification of compliance with tax laws from Oregon Employment Department, Oregon Department of Revenue, and the Internal Revenue Service;

(I) Written procedures that demonstrate how the applicant will ensure its clients provide adequate training, supervision, and instruction to meet the requirements of ORS chapter 654;

(J) A description of any present or prior experience of providing workers by contract and for a fee in any state;

(K) A record of any proceedings related to bankruptcies, liens, default, or insolvency, including full details of the:

(i) Nature and dates of the actions;

(ii) Outcomes, and conditions imposed, including but not limited to: administrative orders, lawsuits, judgments, and discharges or permitted resignations;

(iii) Name and location of the court or jurisdiction, case numbers, and dates of any past, current, or pending proceedings; and

(iv) Identification numbers of any licenses, registrations, recognitions, or certifications affected by the actions;

(L) A record of any civil or criminal actions involving or demonstrating dishonesty or misrepresentation, including but not limited to fraud, theft, burglary, embezzlement, deception, perjury, forgery, counterfeiting, bribery, extortion, money laundering; or securities, investments, or insurance violations on the part of the applicant or any controlling person. Records of such actions must include full details of:

(i) The nature and dates of the actions;

(ii) Outcomes, sentences, and conditions imposed, including but not limited to administrative orders, charges, guilty pleas, pleas of no contest, criminal convictions, lawsuits, judgments, and discharges or permitted resignations;

(iii) Name and location of the court or jurisdiction, case numbers, and dates of any past, current, or pending proceedings; and

(iv) Identification numbers of any licenses, registrations, recognitions, or certifications affected by the actions;

(M) A record of any administrative, civil, or criminal actions against the applicant by a regulatory agency of any state regarding worker leasing activities. Records must include full details of:

(i) The nature and dates of the actions;

(ii) Outcomes, sentences, and conditions imposed, including but not limited to administrative orders, charges, guilty pleas,

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pleas of no contest, criminal convictions, lawsuits, judgments, and discharges or permitted resignations;

(iii) Name and location of the court or jurisdiction, case numbers, and dates of any past, current, or pending proceedings; and

(iv) Identification numbers of any licenses, registrations, recognitions, or certifications affected by the actions;

(b) Complete information for each controlling person, including:

(A) Full name, position, and date of birth;

(B) Any other names used;

(C) Residential and business address;

(D) Phone number;

(E) Email address;

(F) The information required under paragraphs (3)(a)(J) through (M) of this rule;

(c) A notarized affidavit from an authorized representative of the applicant and a statement from each controlling person verifying the information provided is complete and truthful, and that there is no omission of material fact; and

(d) Any additional information requested by the director.

(4) Application for limited leasing license.

Notwithstanding section (3) of this rule, a person may apply for a limited leasing license by submitting [Form 5362](#), "Worker Leasing License Application - Limited."

(a) To qualify for a limited license, the person must:

(A) Be licensed or certified in a state that the director has determined has requirements substantially similar to the requirements of these rules;

(B) Have no more than:

(i) Two Oregon clients; and

(ii) Five leased workers, in total;

(C) Be domiciled in a state other than Oregon;

(D) Not maintain an Oregon location; and

(E) Not directly solicit clients located or domiciled in Oregon;

(b) The application and accompanying documentation must include:

(A) The information required under paragraphs (3)(a)(A) through (I) of this rule;

(B) A notarized signature of an authorized representative of the applicant; and

(C) Any additional information requested by the director;

(c) Upon approval of the application under section (5) of this rule, the applicant must pay the required licensing fee of \$2,050; and

(d) After the license is issued, the licensee must submit a full application under section (3) of this rule within 30 days after the date it no longer qualifies for a limited license under subsection (4)(a).

(5) Review of application.

The director will review complete applications. Following receipt of all information required under section (3) or (4) of this rule:

(a) The director may request additional information to further clarify the information and documentation submitted with the application;

(b) The director may conduct a background investigation of the applicant, an owner, or any controlling person. Information learned through a background investigation, or other information submitted during the application process, may be the basis for the director to refuse to issue or renew a license, or to disqualify the applicant or a controlling person from making further application; and

(c) The director will notify the applicant of the decision to approve or deny the application in writing:

(A) If the application is denied, the notice will include the reason for the denial and how to appeal the decision; or

(B) If the application is approved, the director will issue a license upon receipt of the \$2,050 licensing fee under subsection (2)(d) of this rule.

(6) License renewal.

A license will automatically expire two years after the date it was issued unless renewed by the licensee. To renew a license, the worker leasing company must:

(a) If the license was applied for under section (3) of this rule, submit a complete [Form 5364](#), "Worker Leasing License Application – Renewal," to the director at least 90 days before the expiration of the current worker leasing license. The form and accompanying documentation must include:

(A) The information required under paragraphs (3)(a)(A) through (I) of this rule;

(B) Disclosure of any information required under paragraphs (3)(a)(K) through (M) of this rule that has not been previously disclosed to the director;

(C) Complete information for each controlling person, including:

(i) Full name, position, and date of birth;

(ii) Any other names used;

(iii) Residential and business address;

(iv) Phone number;

(v) Email address; and

(vi) Disclosure of any information required under paragraphs (3)(a)(K) through (M) of this rule that has not been previously disclosed to the director;

(D) A notarized affidavit from an authorized representative of the applicant and a statement from each controlling person verifying the information provided is complete and truthful, and that there is no omission of material fact; or

(b) If the license was applied for under section (4) of this rule, submit a complete [Form 5362](#), "Worker Leasing License Application – Limited," as described under subsection (4)(b) of this rule; and

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(c) Submit any supplemental material necessary to establish a complete application, including any information requested by the director, at least 45 days before expiration of the current license; and

(d) Upon application approval, pay the required licensing fee of \$2,050.

(7) Changes and corrections to application information.

The worker leasing company must notify the director in writing of any changes or corrections to information provided in any application approved under this rule within 30 days of the effective date of the change or knowledge of incorrect information.

(8) Electronic submission of application materials.

Notwithstanding any other section of this rule, with the director's prior authorization, an applicant may submit application materials electronically using the appropriate application form or an electronic equivalent that contains all of the information required by this rule.

(9) Denial of application.

The director may deny an application for initial license or renewal for reasons including, but not limited to:

(a) Misrepresentation of information submitted in the application;

(b) Failure to meet any of the requirements of ORS 656.850, 656.855, or these rules;

(c) Denial of a previous application for, or prior suspension or revocation of, a worker leasing license by the director;

(d) Denial, suspension, or revocation of a license, registration, or certification, or other disciplinary action by any governmental agency or entity;

(e) Having exercised authority, control, or decision-making responsibility concerning any worker leasing company during a time that company had its authorization to provide worker leasing services denied, suspended, revoked, or restricted;

(f) Having been the subject of an order, adverse to the applicant or controlling person, by any governmental agency or entity in connection with any worker leasing activity;

(g) Having been found by any governmental agency or entity to have made a false or misleading statement, material misrepresentation, or material omission, or to have failed to disclose material facts;

(h) Violations of worker leasing statutes or regulations in any state;

(i) Failure to establish minimum experience, training, or education that demonstrates competency in providing worker leasing services;

(j) Nonpayment of taxes, liens, fees, assessments, civil penalties, or any other moneys due the State of Oregon or another jurisdiction;

(k) Having filed for bankruptcy, been declared bankrupt, or been the subject of other proceedings related to insolvency, default, or delinquency;

(l) Having been convicted of, or pleaded guilty or no contest to, any felony or misdemeanor involving dishonesty or misrepresentation, including but not limited to fraud, theft, burglary, embezzlement, deception, perjury, forgery, counterfeiting, bribery, extortion, money laundering; or violations involving securities, investments, or insurance violations on the part of the applicant or any controlling person; or

(m) Having failed to provide documents requested by the director.

(10) Disqualification.

The director may disqualify an applicant or controlling person from applying for a license in the future for any of the reasons listed under section (9) of this rule. If an applicant or controlling person is disqualified:

(a) The applicant or controlling person may not reapply for a license for at least two years from the disqualification date; and

(b) The disqualification may apply to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company's assets to another person, owner, or controlling person.

(11) Appeal of denial or disqualification.

An applicant or controlling person may appeal a denial or disqualification under this rule as provided in OAR 436-180-0008 and OAR 436-001.

Statutory authority: ORS 656.726(4) and 656.855

Statutes implemented: ORS 656.855

Hist: Adopted 6/7/18 as WCD Admin. Order 18-057, effective 7/1/18

436-180-0150 Recordkeeping and Reporting Requirements [Formerly 436-050-0450]

(1) Required records.

A worker leasing company must maintain and make the following records available for review by the director, upon request:

(a) Copies of and documentation of filing for signed forms and notices required under OAR 436-180-0110. All forms and documentation must be maintained for three years after the date coverage provided to a client was terminated;

(b) Copies of signed worker leasing contracts for three years after the termination date of the contract;

(c) Payroll records for the most recent seven years, including records that identify the name, hire date, termination date, and work location for:

(A) Leased workers subject to coverage by the worker leasing company;

(B) Leased workers not subject to coverage by the worker leasing company;

(C) Administrative personnel, and other subject workers directly employed by the worker leasing company; and

(D) Workers provided to clients on a temporary basis, if any.

(2) Records of leased and temporary workers.

If a worker leasing company both provides leased workers and provides workers on a temporary basis, the worker leasing

company must maintain written records that specify which workers are leased and which workers are provided on a temporary basis.

Statutory authority: ORS 656.726(4) and 656.855

Statutes implemented: ORS 656.855

Hist: Adopted 6/7/18 as WCD Admin. Order 18-057, effective 7/1/18

436-180-0155 Reporting Requirements of a Self-Insured Worker Leasing Company [Formerly 436-050-0455]

(1) Reporting of client statistical data.

A self-insured worker leasing company must maintain and report to the National Council on Compensation Insurance (NCCI) separate statistical data for each client the self-insured worker leasing company provides coverage for under OAR 436-180-0100(2). Reporting must be according to the uniform statistical plan prescribed by the director under ORS 737.225(4) and OAR 836-042-0045.

(2) Records relating to client statistical data.

Records relating to the client statistical data for self-insured worker leasing companies must be made available to NCCI, upon request.

Statutory authority: ORS 656.726(4) and 656.855

Statutes implemented: ORS 656.403(4) and 656.855

Hist: Adopted 6/7/18 as WCD Admin. Order 18-057, effective 7/1/18

436-180-0160 Suspension or Revocation of License [Formerly 436-050-0460]

(1) General.

The director may suspend or revoke a worker leasing license for reasons including, but not limited to:

(a) Failure to comply with the provisions of ORS chapters 654, 656, 659, 659A, 731 or 737; or these rules;

(b) Denial, suspension, or revocation of a license, registration, or certification, or other disciplinary action by any governmental agency or entity involving worker leasing activities;

(c) Nonpayment of taxes, fees, assessments, civil penalties, or any other moneys due the State of Oregon or another jurisdiction;

(d) Filing for bankruptcy, being declared bankrupt, or being the subject of other proceedings related to default on or delinquency of payment of financial obligations;

(e) Insolvency, if the worker leasing company's liabilities exceed its assets or the worker leasing company cannot meet its financial obligations;

(f) A conviction, guilty plea, or plea of no contest, within the last 10 years, for any felony or misdemeanor involving dishonesty or misrepresentation, including but not limited to fraud, theft, burglary, embezzlement, deception, perjury, forgery, counterfeiting, bribery, extortion, money laundering; or violations involving securities, investments, or insurance violations on the part of the applicant or any controlling person; or

(g) The worker leasing company or controlling person is permanently or temporarily enjoined by a court from engaging in or continuing any conduct or practice involving any aspect of the worker leasing business.

(2) Show-cause hearing.

Except as described under section (3) of this rule, the director will not suspend or revoke a worker leasing license until the worker leasing company has been given notice and the opportunity to be heard through a show-cause hearing with the director.

(a) During the show-cause hearing, the worker leasing company will be provided an opportunity to:

(A) Present evidence regarding any proposed orders by the director to suspend or revoke the worker leasing company's license; and

(B) Give reason why the worker leasing company should be permitted to continue performing services as a worker leasing company.

(b) A show-cause hearing may be held at any time the director finds that a worker leasing company has failed to comply with the requirements of ORS chapter 656, these rules, or the orders of the director.

(3) Emergency order of suspension or revocation.

Notwithstanding section (2) of this rule, the director may immediately:

(a) Suspend a license by issuing an "emergency suspension order" if:

(A) The worker leasing company fails to maintain coverage; or

(B) The director finds there is a serious danger to public health or safety; or

(b) Revoke a license upon discovery of a misrepresentation in the information submitted in the worker leasing application.

(4) Suspension of license.

If the director suspends a worker leasing license:

(a) The worker leasing company and any controlling person may not lease workers to clients for a specified period of time, up to two years;

(b) The suspension may apply to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company's assets to another person; and

(c) When the suspension expires, the worker leasing company or controlling person may petition the director to resume its worker leasing company activities, or apply to renew its worker leasing license under OAR 436-180-0140.

(5) Revocation of license.

If the director revokes a worker leasing license:

(a) The worker leasing company, and any controlling person may not lease workers to clients for at least five years;

(b) The revocation may apply to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company's assets to another person; and

(c) After a revocation has been in effect for five years or longer, the worker leasing company or controlling person may reapply for license under OAR 436-180-0140.

(6) Appeal of suspension or revocation.

A proposed and final order of suspension or revocation issued under this rule may be appealed under OAR 436-180-0008 and OAR 436-001.

Statutory authority: ORS 656.726(4) and 656.855
Statutes implemented: ORS 656.850 and 656.855
Hist: Adopted 6/7/18 as WCD Admin. Order 18-057, effective 7/1/18

436-180-0170 Monitoring and Auditing [Formerly 436-050-0470]

(1) Generally.

The director will monitor and conduct periodic audits of employers as necessary to ensure compliance with the worker leasing company licensing and performance requirements.

(2) Disclosure of worker leasing records.

A worker leasing company must make all records required by these rules available to the director upon request. The records must be made available at no cost to the director.

(3) Inspection of books, records, and payroll.

Under ORS 656.726 and 656.758, the director may inspect the books, records, and payrolls of employers pertinent to the administration of these rules. Employers must make all pertinent books, records, and payrolls available for inspection by the director upon request and without cost.

(4) "Employer" defined.

For the purposes of this rule, "employer" includes a worker leasing company, temporary service provider, and client.

Statutory authority: ORS 656.726(4) and 656.855
Statutes implemented: ORS 656.855
Hist: Adopted 6/7/18 as WCD Admin. Order 18-057, effective 7/1/18

436-180-0200 Assessment of Civil Penalties [Formerly 436-050-0480]

(1) Failure to comply with statutes, rules, and orders of the director.

The director may assess a civil penalty against a worker leasing company that fails to comply with the requirements of ORS 656.850 or 656.855, OAR 436-180, or the orders of the director.

(2) Failure to comply with OAR 436-180-0170.

The director may assess a civil penalty against any employer that fails to respond to requests for information or fails to meet the requirements of 436-180-0170. Assessment of a penalty does not relieve the employer of the obligation to provide a response.

(3) Leasing workers without a license.

The director may assess a civil penalty against any person who is found to be operating a worker leasing company without a valid license. For the purposes of this section, any month or part of a month a person provides leased workers to a client without a valid license is a separate violation.

(4) Obtaining workers from an unlicensed worker leasing company.

The director may assess a civil penalty against an employer that leases or continues to lease workers from an unlicensed

worker leasing company after written notice of such violation has been served.

(5) Penalties under ORS 656.990.

Any person or controlling person that knowingly makes any false statement or representation may also be subject to penalties under ORS 656.990.

Statutory authority: ORS 656.726(4) and 656.855
Statutes implemented: ORS 656.745, 656.850, 656.855, and 656.990
Hist: Adopted 6/7/18 as WCD Admin. Order 18-057, effective 7/1/18