December 23, 2025

Notice of permanent changes to workers' compensation rules

Caption: Implementation of HB 2802 (2025), changes to OAR 436-060 Claims Administration

The Workers' Compensation Division has adopted permanent changes to:

- OAR 436-060 Claims Administration
- OAR 436-030 Claim Closure and Administration (limited change)
- OAR 436-075 Retroactive Program (limited change)

These changes are **effective** Jan. 1, 2026.

Rulemaking Notice was published in the November 2025 *Oregon Bulletin*.

Summary of changes:

OAR 436-060

- OAR 436-060-0018 is amended to:
  - Remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.
  - Specify that an appeal of the worker's request for reconsideration is a request for review, and that an appeal of the director's order is a request for hearing.
- OAR 436-060-0020 is amended to:
  - Remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.
- OAR 436-060-0025 is amended to:
  - Modify the definition of "pay rate change" to clarify how to calculate the worker's weekly wage when the worker has wages paid at a fluctuating pay rate.
  - Specify when a one-time bonus (such as a sign-on or relocation bonus) may not be included in the weekly wage calculation.
- OAR 436-060-0030 is amended to:
  - Clarify post-injury wages are not limited to only wages "from any kind of work."
  - Remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.
  - Clarify that post-injury wages must offset the temporary disability benefit paid when a modified job no longer exists or the job offer is withdrawn.
- OAR 436-060-0035 is amended to:

  - Specify that an appeal related to the end of, or eligibility for, supplemental disability benefits is a request for hearing.
  - Clarify that the worker may request a hearing on the assigned processing administrator's decision concerning eligibility for supplemental disability or the rate of supplemental disability.
- OAR 436-060-0060 is amended to align with statutory changes under HB 2802 (2025), effective Jan. 1, 2026.
- OAR 436-060-0075 is amended to clarify the end date of permanent total disability benefits.
- OAR 436-060-0095 is amended to:
  - Remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.
- OAR 436-060-0105 is amended to remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.
- OAR 436-060-0135 is amended to remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.
- OAR 436-060-0137 is amended to:
  - Specify that an appeal related to the director's decision approving or denying more than three vocational evaluations is a request for hearing.
  - Remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.
- OAR 436-060-0140 is amended to:
  - Clarify when a Modified Notice of Acceptance must be issued.
  - Specify the title of a document when a Modified Notice of Acceptance is combined with an Updated Notice of Acceptance.
- OAR 436-060-0141 is repealed.
- OAR 436-060-0155 is amended to change when a penalty payment following a stipulation is due.
- OAR 436-060-0200 is amended to remove and update provisions related to civil penalties, performance audits, and considerations for assessing penalties.
- OAR 436-060-0500 is amended to clarify what settlements must be submitted to the division in order to receive reimbursement from the Workers' Benefit Fund for supplemental disability benefits.

OAR 436-030

- OAR 436-030-0135 is amended to clarify when a reconsideration proceeding will not be conducted, due to the worker obtaining a lump sum after waiving the right to request reconsideration.

OAR 436-075

- OAR 436-075-0030 is amended to add a reference to OAR 436-060, to clarify the end date of permanent total disability benefits.

	Matt West	12/23/25
Authorized Signer	Printed name	Date

Final rules, with marked changes, have been posted to the Workers' Compensation Division's website:
https://wcd.oregon.gov/laws/Pages/new-rules.aspx.

Mailing distribution: Agency email lists

Claim Closure and Reconsideration Oregon Administrative Rules Chapter 436, Division 030

Proposed Effective Jan. 1, 2026

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Summary of changes effective Jan. 1, 2026:

- OAR 436-030-0135 is amended to clarify when a reconsideration proceeding will not be conducted, due to the worker obtaining a lump sum after waiving the right to request reconsideration.

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 030

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 2/12/15 as WCD Admin. Order 15-057, eff. 3/1/15
Amended 4/10/17 as WCD Admin. Order 17-053 (temporary/expired), eff. 4/11/17 through 10/7/17
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
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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.

(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 10/12/15 as Admin. Order 15-061, eff. 11/17/15
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 12/1/2009 as WCD Admin. Order 09-056 eff. 1/1/2010
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
Statutory minor correction (repeal of ORS 656.750)– ORS 183.335(7), filed and effective 6/18/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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:

"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.

(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, 656.268 (OL2022, ch. 73, sections 4 & 5), 656.331, 656.726
Hist: Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
Amended 6/13/22 as Admin. Order 22-056, eff. 7/1/22
Amended 12/19/22 as Admin. Order 22-068, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 12/1/2009 as WCD Admin. Order 09-056 eff. 1/1/2010
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 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:

(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 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 9/7/17 as WCD Admin. Order 17-056, eff. 10/8/17
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
Amended 12/19/22 as Admin. Order 22-068, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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.

(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 10/12/15 as Admin. Order 15-061, eff. 11/17/15
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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.

(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 1/29/15 as Admin. Order 15-052, eff. 3/1/15
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 "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 9/7/17 as WCD Admin. Order 17-056, eff. 10/8/17
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
Amended 12/19/22 as Admin. Order 22-068, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 10/26/04 as WCD Admin. Order 04-062, eff. 1/1/05
Amended 11/17/11 as WCD Admin. Order 11-058, eff. 1/1/12
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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:

(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 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
Amended 6/13/22 as Admin. Order 22-056, eff. 7/1/22
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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.

(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 1/29/15 as Admin. Order 15-052, eff. 3/1/15
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 10/26/04 as WCD Admin. Order 04-062, eff. 1/1/05
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 436-030-0145. 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 10/12/15 as Admin. Order 15-061, eff. 11/17/15
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 10/12/15 as Admin. Order 15-061, eff. 11/17/15
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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) The director will not conduct a reconsideration proceeding ~~W~~when:

(a) The Notice of Closure was issued on or after January 1, 2026;

(b) ~~a~~The worker has requested ~~and cashed~~ a lump-sum payment of a permanent partial disability award granted by the Notice of Closure~~,~~ under ORS 656.230;

(c) The worker has waived the right to request reconsideration of the Notice of Closure; and

(d) A lump-sum payment is required 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 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 5/21/15 as Admin. Order 15-059, eff. 5/21/15 (Temp)
Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15
Amended 12/23/25 as Admin. Order 25-057, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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
Hist: Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15

Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 12/1/2009 as WCD Admin. Order 09-056 eff. 1/1/2010
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 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 10/10/17 as Admin. Order 17-058, eff. 1/1/18
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 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 11/1/07 as WCD Admin. Order 07-059, eff. 1/2/08
Amended 7/5/22 as WCD Admin. Order 22-062, eff. 9/1/22
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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

(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 11/1/07 as WCD Admin. Order 07-059, eff. 1/2/08
Amended 12/1/2009 as WCD Admin. Order 09-056 eff. 1/1/2010
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06
Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 12/5/05 as WCD Admin. Order 105-073 eff. 1/1/07
Amended 12/1/2009 as WCD Admin. Order 09-056 eff. 1/1/2010
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

Claims Administration
Oregon Administrative Rules
Chapter 436, Division 060

Proposed Effective January 1, 2026

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

Summary of changes effective Jan. 1, 2026:

- OAR 436-060-0018 is amended to:
  - Remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.
  - Specify that an appeal of the worker's request for reconsideration is a request for review, and that an appeal of the director's order is a request for hearing.
- OAR 436-060-0020 is amended to:
  - Remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.
- OAR 436-060-0025 is amended to:
  - Modify the definition of "pay rate change" to clarify how to calculate the worker's weekly wage when the worker has wages paid at a fluctuating pay rate.
  - Specify when a one-time bonus (such as a sign-on or relocation bonus) may not be included in the weekly wage calculation.
- OAR 436-060-0030 is amended to:
  - Clarify post-injury wages are not limited to only wages "from any kind of work."
  - Remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.
  - Clarify that post-injury wages must offset the temporary disability benefit paid when a modified job no longer exists or the job offer is withdrawn.
- OAR 436-060-0035 is amended to:
  - Specify that an appeal related to the end of, or eligibility for, supplemental disability benefits is a request for hearing.
  - Clarify that the worker may request a hearing on the assigned processing administrator's decision concerning eligibility for supplemental disability or the rate of supplemental disability.
- OAR 436-060-0060 is amended to align with statutory changes under HB 2802 (2025), effective Jan. 1, 2026.
- OAR 436-060-0075 is amended to clarify the end date of permanent total disability benefits.
- OAR 436-060-0095 is amended to:
  - Remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.
- OAR 436-060-0105 is amended to remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.
- OAR 436-060-0135 is amended to remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.
- OAR 436-060-0137 is amended to:
  - Specify that an appeal related to the director's decision approving or denying more than three vocational evaluations is a request for hearing.
  - Remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.
- OAR 436-060-0140 is amended to:
  - Clarify when a Modified Notice of Acceptance must be issued.
  - Specify the title of a document when a Modified Notice of Acceptance is combined with an Updated Notice of Acceptance.
- OAR 436-060-0141 is repealed.
- OAR 436-060-0155 is amended to change when a penalty payment following a stipulation is due.
- OAR 436-060-0200 is amended to remove and update provisions related to civil penalties, performance audits, and considerations for assessing penalties.
- OAR 436-060-0500 is amended to clarify what settlements must be submitted to the division in order to receive reimbursement from the Workers' Benefit Fund for supplemental disability benefits.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
CLAIMS ADMINISTRATION

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 060

NOTE: Revisions are marked as follows: new text | ~~deleted text~~.

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.

(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 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

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

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 7/17/18 as WCD Admin. Order 18-058, eff. 8/1/18

Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
Amended 12/13/21 as WCD Admin. Order 21-056, eff. 1/1/22
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
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 12/1/2009 as WCD Admin. Order 09-057, eff. 1/1/2010
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
Statutory minor correction (repeal of ORS 656.750)– ORS 183.335(7), filed and effective 6/18/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
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

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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:

(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: Adopted 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
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: Adopted 12/1/2009 as WCD Admin. Order 09-057, eff. 1/1/2010
Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16
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 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
Amended 12/13/21 as WCD Admin. Order 21-056, eff. 1/1/22
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
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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:

(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 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
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
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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.

- 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 submit a request for review~~appeal~~ to the director under section (7) of this rule:

(A) The request for review~~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 request review of~~appeal~~ the insurer's reclassification decision under section (3) or (6) of this rule. If a worker requests review of~~appeals~~ an insurer's reclassification decision:

(A) The worker's request for review~~appeal~~ must be copied to the insurer;

(B) The director will acknowledge receipt of the request for review~~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 director's order to request a hearing~~appeal the director's decision to~~ by 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
Amended 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 10/26/04 as WCD Admin. Order 04-064, eff. 1/1/05
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 , and 656.726(4)
Statutes implemented: ORS 656.210, 656.212, 656.245, 656.262, 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
Amended 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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. A pay rate change does not include fluctuations in the rate based on the number of hours worked in a period.

(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) One-time bonus.

A one-time bonus (for example, a sign-on bonus or relocation bonus) paid to the worker for accepting a job offer may not be included in the wages used to calculate the worker's weekly wage.

(10) 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
Amended 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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;

(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, if~~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 face 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:

- 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) Temporary disability paid under this section must be calculated under (1) of this rule, accounting for any post-injury wages.

(b) This section applies to situations including, but not limited to, termination of temporary employment, layoff, or plant closure.

(c~~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.

(d~~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).

(e~~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 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
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Amended 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 request a hearing by~~appeal that action to~~ the ~~Workers' Compensation B~~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 or the assigned processing administrator's decision concerning the worker's eligibility for supplemental disability or the rate of supplemental disability, the worker must submit the request for hearing~~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 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
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See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 10/26/04 as WCD Admin. Order 04-064, eff. 1/1/05
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 11/1/07 as WCD Admin. Order 07-064, eff. 1/1/08
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0060 Lump--Sum Payment of Permanent Partial Disability Awards

(1) General.

(a) This section applies to claims in which a Notice of Closure is issued on or after Jan. 1, 2026.

(b) When the total amount of ~~an~~the 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 payment. When the total amount of 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.

(A) Subject to paragraph (B) of this subsection, if the worker or worker's attorney has requested a lump-sum payment of an award where the total amount of the award exceeds $6,000, t~~T~~he insurer must make the payment requested if ~~may only deny the request for lump sum payment if any of the following apply~~:

(i) The worker has waived the right to request reconsideration of the Notice of Closure; or

(ii) The award has become final by operation of law.

(B) The insurer is not required to make the payment requested if:

(i) The insurer timely requests reconsideration of the Notice of Closure under ORS 656.268(5)(e) and the reconsideration proceeding has not yet been completed;

~~**(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;~~

(ii~~e~~) The payment of compensation has been stayed pending a request for hearing or review under ORS 656.313; or

(iii~~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:

(I~~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;

(II~~B~~) Is actively enrolled and engaged in an authorized training plan under OAR 436-120; or

(III~~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
Amended 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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) Notwithstanding OAR 436-075-0030(3), permanent total disability benefits must be paid through the date of death. 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 must pay death benefits to surviving beneficiaries in the same manner and same amounts as provided in sections (2) through (6) of this rule.~~:~~ Death

~~**(A)** Permanent total disability benefits must be paid through the date of death. B~~benefits under this section begin to accrue the ~~following~~ calendar day after the date of death~~; 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~~;

(d~~e~~) The insurer is not required to reopen and close the claim to begin making payments under this section; and

(e~~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 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
Amended 6/13/22 as Admin. Order 22-057, eff. 7/1/22
Amended 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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.

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.

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
Amended 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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;

(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 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
Amended 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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
Amended 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26

See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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.

(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 by requesting a hearing by~~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 face 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:

(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 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."~~**

~~**(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
Amended 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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.

(A) If the "Initial Notice of Acceptance" is combined with the "Updated Notice of Acceptance at Closure" in the same document, both titles must appear near the top of the document.

(B) If the "Modified Notice of Acceptance" is combined with the "Updated Notice of Acceptance at Closure" in the same document, both titles must appear near the top of the document.

(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
Amended 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

~~**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: Adopted 9/30/20 as WCD Admin. Order 20-061, eff. 10/1/20 (temp)~~

~~Amended 1/26/21 as WCD Admin. Order 21-050, eff. 2/1/21~~

Repealed 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26

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 12/14/17 as WCD Admin. Order 17-062, eff. 1/1/18
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
Amended 12/19/22 as WCD Admin. Order 22-069, eff. 1/1/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 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.

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 12/14/17 as WCD Admin. Order 17-062, eff. 1/1/18
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
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
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 12/1/2009 as WCD Admin. Order 09-057, eff. 1/1/2010
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 12/19/22 as WCD Admin. Order 22-067, eff. 1/1/23
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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) Notwithstanding (5) of this rule, ~~P~~payment of a penalty due under this section must be paid ~~is due within 14 days after the date the director approves the stipulation~~within five business days of the date the director's order approving the stipulation becomes final, unless a different payment date is~~otherwise~~ stated in the stipulation. The penalty is considered paid under the same conditions provided under OAR 436-060-0150(1). 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
Amended 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 10/2/02 as WCD Admin. Order 02-059, eff. 11/1/02
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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(12),(13),(14), and (16)
Hist: Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
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
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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;

(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.

(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 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
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
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 12/1/2009 as WCD Admin. Order 09-057, eff. 1/1/2010
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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.~~

(3~~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.

(4~~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 specified for the audit~~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.~~

(5~~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 12/17/19 as Admin. Order 19-064, eff. 1/1/20
Amended 12/19/22 as WCD Admin. Order 22-067, eff. 1/1/23
Amended 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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: Adopted 12/1/2009 as WCD Admin. Order 09-057, eff. 1/1/2010
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, disputed claim settlements, and settlement stipulationsed claims settlements.

Claim dispositions agreements under ORS 656.236, disputed claim settlements under ORS 656.289, or other settlement stipulationsed claims settlements regarding matters under ORS chapter 656, 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, or stipulation is approved by the Worker's Compensation Board.

(a) For the purpose of this section, a "settlement stipulation" means a written agreement or an oral agreement if made on the oral record of a hearing and approved in writing by an administrative law judge, in which any matter contested between the parties, other than matters resolvable in a claim disposition agreement under ORS 656.236 or a disputed claim settlement under ORS 656.289, are resolved by agreement of the parties.

(b) To receive written confirmation of a proposed disposition, or settlement, or stipulation, 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, or stipulation, 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.

(cb) The director will not confirm the disposition, settlement, or stipulation 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 12/23/25 as WCD Admin. Order 25-055, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 and656.605
Hist: Amended 12/1/2009 as WCD Admin. Order 09-057, eff. 1/1/2010
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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%

Retroactive Program
Oregon Administrative Rules
Chapter 436, Division 075

Proposed Effective Jan. 1, 2026

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NOTE: Substantive revisions are indicated by vertical lines in the right margin.

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

Summary of changes effective Jan. 1, 2026:

- OAR 436-075-0030 is amended to add a reference to OAR 436-060, to clarify the end date of permanent total disability benefits.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
RETROACTIVE PROGRAM

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 075

NOTE: Revisions are marked as follows: new text | ~~deleted text~~.

436-075-0001 Authority for Rules *(Repealed)*

Statutory authority: ORS 656.506 and 656.726
Statutes implemented: ORS 656.506
Hist: Filed 12/22/89 as WCD Admin. Order 6-1989, eff. 1/1/1990
Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
Repealed 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18

436-075-0002 Purpose *(Repealed)*

Statutory authority: ORS 656.506
Statutes implemented: ORS 656.506
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98
Repealed 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18

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 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98
Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98
Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-075-0006 Administration of Rules *(Repealed)*

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.726
Hist: Filed 12/22/89 as WCD Admin. Order 6-1989, eff. 1/1/90
Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
Repealed 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, 656.750
Hist: Amended 10/19/05 as WCD Admin. Order 05-065, eff. 1/2/06

Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18
Statutory minor correction (repeal of ORS 656.750)– ORS 183.335(7), filed and effective 6/18/24
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 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 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98
Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98
Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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) Except as specified in OAR 436-060-0075(7), ~~B~~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 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18
Amended 12/23/25 as WCD Admin. Order 25-056, eff. 1/1/26
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98
Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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.

Statutory authority: ORS 656.506
Statutes implemented: ORS 656.210
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98
Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 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.

Statutory authority: ORS 656.506, 656.726(4)
Statutes implemented: ORS 656.236, 656.289
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98
Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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.

Statutory authority: ORS 656.506, 656.726(4)
Statutes implemented: ORS 656.506
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98
Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98
Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
Amended 12/14/17 as WCD Admin. Order 17-063, eff. 1/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 11/29/90 as WCD Admin. Order 23-1990, eff. 12/26/90
Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.