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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

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RULES:
436-030-0135, 436-060-0018, 436-060-0020, 436-060-0025, 436-060-0030, 436-060-0035, 436-060-0060, 436-060-0075, 436-060-0095, 436-060-0105, 436-060-0135, 436-060-0137, 436-060-0140, 436-060-0141, 436-060-0155, 436-060-0200, 436-060-0500, 436-075-0030

AMEND: 436-030-0135

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: 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.

CHANGES TO RULE:

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) ~~W~~The~~n a worker has requested and cash~~ director will not conduct a reconsideration proceeding when:¶
(a) The Notice of Closure was issued on or after January 1, 2026;¶
(b) The worker has requested a lump-~~-~~sum payment~~, under ORS 656.230, of an~~ of a permanent partial disability award granted by ~~a~~the Notice of Closure~~, the director will not consider the adequacy of that award in a reconsideration proceeding~~ 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.¶
(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/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.268 (2015 OL Ch. 144)

AMEND: 436-060-0018

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: 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.

CHANGES TO RULE:

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 ~~appeal~~submit a request for review to the director under section (7) of this rule:¶
(A) The ~~appeal~~request for review must be made no later than the 60th day after the mailing date of the Notice of Refusal to Reclassify; and¶
(B) A copy of the insurer's Notice of Refusal to Reclassify must be provided to the director.¶
(d) If the insurer does not respond to the worker's request for reclassification within 14 days of receipt of the worker's request:¶
(A) The worker may request review by the director under section (7) of this rule as if the insurer issued a Notice of Refusal to Reclassify;¶
(B) The director may assess civil penalties under OAR 436-060-0200; and¶
(C) The director may assess an attorney fee under ORS 656.386(3).¶
(e) If the worker is represented by an attorney, and the attorney is instrumental in obtaining an order from the director that reclassifies the claim from nondisabling to disabling, the director may order a reasonable assessed attorney fee under ORS 656.277 and OAR 436-001-0435.¶
(4) Time frame for aggravation rights. A claim for aggravation under ORS 656.273 must be filed within five years after:¶
(a) The first valid closure of a claim that is reclassified from nondisabling to disabling within one year from the date of acceptance; or¶
(b) The date of injury of a claim that is not reclassified from nondisabling to disabling within one year from the date of acceptance.¶
(5) Claims for aggravation on nondisabling claims. When a claim has been classified as nondisabling for at least one year after the date of acceptance, a worker who believes the claim was or has become disabling may submit a claim for aggravation under ORS 656.273.¶
(6) Reclassification of a disabling claim. If a claim has been accepted and classified as disabling:¶
(a) All aspects of the claim are classified as disabling and may not be reclassified, unless:¶
(A) The claim has been classified as disabling for less than one year from date of acceptance;¶
(B) The insurer determines the criteria for a disabling claim were never satisfied; and¶
(C) The insurer has notified the worker and the worker's attorney, if any, by issuing a Modified Notice of Acceptance. The Modified Notice of Acceptance must include:¶
~~(i) The following statement in bold text:¶~~
~~"Notice to Worker: Your claim has been reclassified to nondisabling. Generally, this means your insurer concluded no disability payments are due and all of the following are true:¶~~
~~You were able to return to work at full wages on or before the fourth calendar day after leaving work or losing wages as a result of your injury.¶~~
~~You did not lose time or wages from work as a result of your injury on or after that fourth calendar day.¶~~
~~It appears you will not have any permanent disability as a result of your injury.¶~~
~~If you think there is a mistake in the classification of your claim as nondisabling, contact the insurer within one year of the date the insurer first accepted your claim and request reclassification.¶~~
~~If you request reclassification, the insurer must complete its review and send you its decision within 14 days of~~

~~receiving your request. If you disagree with the insurer's decision, you have the right, within 60 days of the date of the insurer's notice, to request that the Workers' Compensation Division review your claim to determine if it was correctly classified. If the insurer does not respond to your request for reclassification within 14 days of receiving your request, you may ask the Workers' Compensation Division to review your claim as though the insurer refused to reclassify your claim. For assistance, you may call the Workers' Compensation Division at 503-947-7816, or the Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)."¶~~
~~(ii) Effective no later than Oct. 1, 2024, the statement in (C)(i) of this subsection must be replaced with~~ the following language in bold and formatted as follows:¶
Notice to worker: ¶
¶
We have changed your claim to nondisabling. Generally, this means no disability payments are due and all of the following are true: ¶
¶
- You were able to return to work with full wages by the fourth calendar day after leaving work or losing wages because of your injury. ¶
- You did not lose time or wages from work because of your injury on or after that fourth calendar day. ¶
- It appears you will not have any permanent disability because of your injury. ¶
¶
If you disagree that your claim is nondisabling, you may request that we change your claim to disabling. ¶
¶
- You must send us your request in writing within one year of the date we first accepted your claim. ¶
- We must review and send you our decision within 14 days of receiving your request. ¶
¶
If you disagree with our decision, or we do not respond to your request, you have the right to appeal to the Workers' Compensation Division. To appeal: ¶
¶
- You must ask the division to review your claim within 60 days of the date we mailed you our decision. ¶
- If we did not respond within 14 days of receiving your request, ask the division to review your claim as if we refused to change your claim. ¶
¶
For help, call: ¶
- Workers' Compensation Division at 503-947-7816 ¶
- Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)¶
(b) Any subsequently accepted conditions or aggravations must be processed as disabling claims; and¶
(c) Claim closure must be processed under ORS 656.268.¶
(7) Appeal of insurer's classification decision. If a worker disagrees with an insurer's decision to not reclassify the worker's claim from nondisabling to disabling, the worker may appeal the decision by requesting review by the director:¶
(a) The request must be submitted to the division by mail, hand-delivery, fax, or phone within 60 days from the date of the insurer's notice;¶
(b) The worker may use Form 2943, "Worker Request for Claim Classification Review," for requesting review of the insurer's claim classification decision; and¶
(c) The worker does not need to be represented by an attorney to ~~appeal~~request review of the insurer's reclassification decision under section (3) or (6) of this rule. If a worker ~~appeals~~requests review an insurer's reclassification decision:¶
(A) The worker's ~~appeal~~request for review must be copied to the insurer;¶
(B) The director will acknowledge receipt of the ~~appeal~~request for review in writing to the worker, the worker's attorney, if any, and the insurer, and initiate the review;¶
(C) Within 14 days of the director's acknowledgement:¶
(i) The insurer must provide the director and all other parties with the complete medical record and all official actions and notices on the claim. The director may impose penalties against an insurer under OAR 436-060-0200 if the insurer fails to provide claim documents in a timely manner; and¶
(ii) The worker may submit any additional evidence for the director to consider. Copies must be provided to all other parties at the same time; and¶
(D) After receipt and review of the required documents, the director will issue an order:¶
(i) The worker and the insurer have 30 days from the mailing date of the ~~order to appeal the director's decision to~~director's order to request a hearing by the board; and¶
(ii) The director may reconsider, abate, or withdraw any order before the order becomes final by operation of law.
Statutory/Other Authority: ORS 656.268, ORS 656.277, ORS 656.386, ORS 656.726(4), ORS 656.745

Statutes/Other Implemented: ORS 656.268, ORS 656.277, ORS 656.386, ORS 656.745, ORS 656.210, ORS 656.212, ORS 656.214, ORS 656.262, ORS 656. 273

AMEND: 436-060-0020

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: OAR 436-060-0020 is amended to:

-Remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.

CHANGES TO RULE:

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/Other Authority: ORS 656.210(2), ORS 656.245, ORS 656.262, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.262, ORS 656.210, ORS 656.212, ORS 656.307

AMEND: 436-060-0025

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: 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.

CHANGES TO RULE:

436-060-0025
Workers 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/Other Authority: ORS 656.210(2), ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.704, ORS 656.210

AMEND: 436-060-0030

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: 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.

CHANGES TO RULE:

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 OAR436-060-0025(1);¶
(c) If a worker is not eligible for supplemental disability under OAR 436-060-0035, wages from a secondary employer must only be included in post-injury wages to the extent that the wages from the secondary employer post-injury exceed the wages from the secondary employer at the time of injury.¶
(d) If the worker's rate of temporary total disability compensation is based on an assumed wage, the rate of temporary partial disability must be calculated by multiplying the rate of temporary total disability by the percentage of hours lost by the worker post injury.¶
(2) If the worker returns to employment. The insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation from the date an injured worker returns to regular or modified employment, prior to claim closure.¶
(a) If the worker is with a new employer, and the insurer asks the worker to provide wage information, the worker is responsible for providing documented evidence of the amount of any wages being earned; and¶
(b) If the worker fails to provide documentation, the insurer may assume that post-injury wages are the same as or higher than the worker's wages at time of injury.¶
(3) If the worker fails to begin employment. Except when the worker refuses modified work under ORS 656.268(4)(c), the insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation as if the worker had begun the employment from the date a worker fails to begin regular or modified employment, ~~and~~if the following conditions have been met:¶
(a) The employer or insurer:¶
(A) Notified the attending physician or authorized nurse practitioner of the physical tasks to be performed by the injured worker;¶
(B) Notified the attending physician or authorized nurse practitioner of the location of the modified work offer; and¶
(C) Asked the attending physician or authorized nurse practitioner if the worker can, as a result of the compensable injury, physically commute to and perform the job.¶
(b) The attending physician or authorized nurse practitioner agreed the employment appears to be within the worker's capabilities, and considering the compensable injury the worker is physically able to commute the lesser of the distance from:¶
(A) The worker's residence at the time of injury to the work site; or¶

(B) The worker's residence at the time of the modified work offer to the work site; and¶
(c) The employer or insurer confirmed the offer of employment in writing to the worker stating:¶
(A) The beginning time, date, and place;¶
(B) The duration of the job, if known;¶
(C) The wages;¶
(D) An accurate description of the physical requirements of the job;¶
(E) The attending physician or authorized nurse practitioner has found the job to be within the worker's capabilities and the commute to be within the worker's physical capacity;¶
(F) The worker's right to refuse the offer of employment without termination of temporary total disability if any of the following conditions apply:¶
(i) The offer is at a site more than 50 miles from the location where the worker was injured or where the worker customarily reported for work, unless the work site is less than 50 miles from the worker's residence, or the job at the time of injury involved multiple or mobile work sites as established by the intent of the employer and worker at the time of hire or the employment pattern before the injury;¶
(ii) The offer is not with the employer at injury;¶
(iii) The offer is not at a work site of the employer at injury;¶
(iv) The offer is not consistent with existing written shift change policy or common practice of the employer at injury or aggravation; or¶
(v) The offer is not consistent with an existing shift change provision of an applicable union contract; and¶
(G) The following notice:~~¶~~
~~(i) In prominent or bold text:¶~~
~~"If you refuse this offer of work for any of the reasons listed in this notice, you should write to the insurer or employer and tell them your reasons for refusing the job. If the insurer reduces or stops your temporary total disability and you disagree with that action, you have the right to request a hearing. To request a hearing you must send a letter objecting to the insurer's actions to the Worker's Compensation Board, 2601 25th Street SE, Suite 150, Salem, Oregon 97302-1282."¶~~
~~(ii) Effective no later than Oct. 1, 2024, the text in (G)(i) of this subsection must be replaced with the following language~~ in bold and formatted as follows:¶
If you refuse this offer of work for any of the reasons listed in this notice, you should: ¶
¶
- 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.¶
(~~b~~c) A worker who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim is subject to this section.¶
(~~c~~d) For the purpose of this rule, when a worker who has been doing modified work quits the job, or the employer terminates the worker for violation of work rules or other disciplinary reasons, it is not a withdrawal of a job offer by the employer, but must be considered the same as the worker refusing wage earning employment under ORS 656.325(5)(a).¶
(~~d~~e) 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/Other Authority: ORS 656.212, 656.704, 656.726(4)
Statutes/Other Implemented: ORS 656.212, 656.704, 656.726(4), 656.268, 656.325(5)

AMEND: 436-060-0035

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: 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.

CHANGES TO RULE:

436-060-0035
Supplemental Disability for Workers with Multiple Jobs at the Time of Injury ¶

(1) For the purpose of this rule:¶
(a) "Primary job" means the job at which the injury occurred, or the job where the worker was employed at the time of medical verification that the worker is unable to work because of disability caused by occupational disease;¶
(b) "Secondary job" means any other job held by the worker in Oregon subject employment at the time of injury;¶
(c) "Temporary disability" means wage loss replacement for the primary job;¶
(d) "Supplemental disability" means wage loss replacement for the secondary jobs that exceeds the temporary disability, up to, but not exceeding, the maximum established by ORS 656.210; and¶
(e) "Insurer" has the same meaning as OAR 436-060-0005(13), and also includes service companies.¶
(2) Election to process and pay supplemental disability. An insurer may elect to be responsible for payment and processing of supplemental disability benefits to a worker employed in more than one job at the time of injury. The insurer is not required to inform the director of its election if it elects to process and pay supplemental disability, unless the insurer's last notice to the director was that it would not process and pay supplemental disability. If the insurer informs the director of its election, the insurer must report its election to the director under OAR 436-060-0011(12).¶
(a) The election must be made by the insurer, and applies to all service companies an insurer may use for processing claims.¶
(b) The election remains in effect for all supplemental disability claims the insurer receives until the insurer changes its election.¶
(c) If the insurer has elected to process and pay supplemental disability benefits:¶
(A) The insurer must determine the worker's ongoing entitlement to supplemental disability;¶
(B) The insurer must pay the worker supplemental disability benefits simultaneously with any temporary disability benefits due;¶
(C) The insurer must maintain a record of supplemental disability benefits paid to the worker, separate from temporary disability benefits paid as a result of the job at injury; and¶
(D) The director will reimburse the insurer for supplemental disability paid under OAR 436-060-0500.¶
(d) If the insurer has elected not to process and pay supplemental disability benefits:¶
(A) The director will select an assigned processing administrator who is authorized to process and pay supplemental disability benefits on behalf of the director;¶
(B) The assigned processing administrator must determine the worker's ongoing entitlement to supplemental disability and must pay the worker supplemental disability benefits due once each 14 days; and¶
(C) The insurer and assigned processing administrator must cooperate and communicate, as necessary, to coordinate benefits due.¶
(i) The assigned processing administrator must provide the insurer with any verifiable documentation of wages from a secondary job received from the worker; and¶
(ii) The insurer and assigned processing administrator must retain documentation of shared information.¶
(3) Eligibility for supplemental disability. A worker who was employed at one or more secondary jobs with Oregon subject employers at the time of injury or medical verification of an occupational disease may be eligible to receive supplemental disability if:¶
(a) The worker provides notification of the secondary job to the insurer within 30 days of the insurer's receipt of the initial claim;¶
(b) The rate of compensation for wages at the primary job under OAR 436-060-0025 is less than the maximum temporary disability rate established under ORS 656.210; and¶
(c) The worker provides verifiable documentation of the wages from any secondary jobs at the time of injury or medical verification of an occupational disease within 60 days of the mailing date of the request for

documentation sent under section (4) of this rule. For each secondary job, the documentation must:¶
(A) Identify the Oregon subject employer for each secondary job;¶
(B) Establish that the worker held the secondary job, in addition to the primary job, at the time of injury or medical verification of occupational disease; and¶
(C) Provide adequate information to calculate the average weekly wage under OAR 436-060-0025.¶
(4) Determination of eligibility. Upon receiving notification of a worker's secondary job the insurer must determine the rate of temporary disability compensation for wages at the primary job under OAR 436-060-0025, and:¶
(a) If the rate of temporary disability compensation meets or exceeds the maximum temporary disability rate, the worker is not eligible for supplemental disability benefits; or¶
(b) If the rate of temporary disability is less than the maximum temporary disability rate, the worker may be eligible for supplemental disability benefits. If the worker may be eligible for supplemental disability benefits, the insurer must:¶
(A) Mail the worker a request for verifiable documentation of the worker's wages from any secondary jobs within five business days of notice or knowledge that the worker may be eligible for supplemental disability benefits;¶
(i) The request must inform the worker what verifiable documentation the worker must submit to the insurer or assigned processing administrator, to determine the worker's eligibility for supplemental disability;¶
(ii) The request must clearly state that if the insurer or assigned processing administrator does not receive the required documentation within 60 days of the mailing date of the request, the insurer will determine the worker's temporary disability rate based only on the job at which the injury occurred, and the worker will be found ineligible for supplemental disability;¶
(B) If the insurer has elected not to process and pay supplemental disability benefits under section (2) of this rule, the insurer must also send a copy of the request to the assigned processing administrator. In addition to the requirements of this section, the request must also:¶
(i) Contain the name, address, email address, and telephone number of the assigned processing administrator;¶
(ii) Clearly advise the worker that the verifiable documentation must be sent to the assigned processing administrator; and¶
(C) The insurer or assigned processing administrator must determine the worker's eligibility for supplemental disability within 14 days of:¶
(i) Receipt of the worker's verifiable documentation; or¶
(ii) The end of the 60-day period in the insurer's request, if the worker does not provide verifiable documentation.¶
(c) Any delay in the payment of a higher disability rate because of the worker's failure to provide verifiable documentation under this section will not result in a penalty under ORS 656.262(11).¶
(5) Notification of eligibility determination. The insurer or the assigned processing administrator must determine the worker's eligibility for supplemental disability and must communicate the determination to the worker and the worker's attorney, if any, in writing. If the worker is found ineligible for supplemental disability, the letter must also advise the worker of the reason why they are not eligible, and how to appeal if the worker disagrees with the determination.¶
(6) Calculation of supplemental disability. The insurer or the assigned processing administrator must calculate supplemental disability for an eligible worker by adding the weekly averages of the worker's wages from each secondary job as calculated under OAR 436-060-0025. For the purposes of calculating and payment of supplemental disability:¶
(a) The total rate of supplemental disability may not exceed the difference between the maximum rate of temporary disability under ORS 656.210(1) and the rate of compensation for wages under the worker's primary job;¶
(b) No supplemental disability is due for jobs where the rate of compensation is based on an assumed wage;¶
(c) In no case may an eligible worker receive less compensation than would be paid if based solely on wages from the primary employer;¶
(d) The worker's scheduled days off for the primary job must be used to calculate and pay supplemental disability; and¶
(e) No three-day waiting period applies to supplemental disability benefits.¶
(7) Partial disability. When a worker who is eligible to receive supplemental disability benefits has post-injury wages from either the primary job or any secondary job:¶
(a) The insurer or the assigned processing administrator must calculate the rate of temporary partial disability due to the worker under OAR 436-060-0030 based on the worker's wages from both the primary and secondary jobs;¶
(b) The insurer or the assigned processing administrator must calculate the amount of supplemental disability by subtracting the rate of partial disability due based on wages from only the primary job from the total rate of

compensation due to the worker;¶
(c) If the worker receives post-injury wages from the secondary job equal to or greater than the secondary wages at the time of injury, no supplemental disability is due; and¶
(d) If the worker returns to a job not held at the time of the injury, the insurer or the assigned processing administrator must process supplemental disability under the same terms, conditions and limitations as OAR 436-060-0030.¶
(8) If temporary disability is not due from the primary job. Supplemental disability may be due on a nondisabling claim even if temporary disability is not due from the primary job.¶
(a) A nondisabling claim will not change to disabling status due to payment of supplemental disability.¶
(b) When supplemental disability payments cease on a nondisabling claim, the insurer or the assigned processing administrator must send the worker written notice advising the worker that their supplemental disability payments have stopped and of the worker's right to ~~appeal that action to the Workers' Compensation B~~Request a hearing by the 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~~, the worker must submit an appeal~~ or the rate of supplemental disability, the worker must submit the request for a hearing 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/Other Authority: ORS 656.210, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.210, ORS 656.726(4), ORS 656.212, ORS 656.325(5), ORS 656.704

AMEND: 436-060-0060

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: OAR 436-060-0060 is amended to align with statutory changes under HB 2802 (2025), effective Jan. 1, 2026.

CHANGES TO RULE:

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

(1) General. ~~When an~~¶
(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 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. ~~When~~ 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. ~~The insurer may only deny the~~¶
(A) Subject to paragraph (B) of this subsection, if the worker or worker's attorney has request~~for~~ed a lump-sum payment ~~io~~f an~~y of the following apply~~ award where the total amount of the award exceeds $6,000, the insurer must make the payment requested if:¶
(~~a~~i) The worker has ~~not~~ waived the right to ~~appeal the adequacy of the award;¶~~
~~(b~~request reconsideration of the Notice of Closure; or¶
(ii) The award has ~~not~~ become final by operation of law~~;~~.¶
(~~c~~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;¶
(ii) The payment of compensation has been stayed pending a request for hearing or review under ORS 656.313; or¶
(~~d~~iii) The worker is enrolled and actively engaged in an authorized training plan under OAR 436-120-. For dates of injury before Jan. 1, 2005, the insurer may not approve a request for lump-sum payment of unscheduled permanent disability. For dates of injury on or after Jan. 1, 2005, the insurer may not approve a request for lump-sum payment of work disability when the worker:¶
(~~A~~I) Has been found eligible for an authorized training plan under OAR 436-120 and will start the plan within 30 days of the date of the decision on the lump-sum request;¶
(~~B~~II) Is actively enrolled and engaged in an authorized training plan under OAR 436-120; or¶
(~~C~~III) 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/Other Authority: ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.704, ORS 656.726(4), ORS 656.230

AMEND: 436-060-0075

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: OAR 436-060-0075 is amended to clarify the end date of permanent total disability benefits.

CHANGES TO RULE:

436-060-0075
Payment of Death Benefits
If death results from a worker's compensable injury or occupational disease, benefits must be paid as follows:¶
(1) Final disposition of the body and funeral expenses.¶
(a) The insurer must pay the cost of final disposition of the body and funeral expenses, up to the maximum benefit under ORS 656.204(1); and¶
(b) The worker's estate, beneficiaries, or other parties may submit bills related to final disposition of the body and funeral up to 60 days after the date of death or date of claim acceptance, whichever is later. Any portion of the benefit that remains unpaid after this period must be paid to the worker's estate.¶
(2) Payments to surviving beneficiaries. The following applies to benefits paid under sections (3) through (5) of this rule:¶
(a) Benefits payable for a partial month must be calculated by dividing the monthly benefit by the actual number of days in the month and multiplying that result by the number of days payable;¶
(b) Unless otherwise specified, monthly benefits to beneficiaries must be paid up to the date of any status change; and¶
(c) Payments must be paid within the timeframes established in OAR 436-060-0150(6).¶
(3) Benefit to surviving spouse. If a worker is survived by a spouse, the insurer must pay monthly benefits in an amount equal to 4.35 times 66-2/3 percent of the state average weekly wage to the surviving spouse. Benefits under this section must be paid through the end of the month in which the spouse is no longer eligible to receive benefits under ORS 656.204(2).¶
(4) Benefit to surviving child. If a worker is survived by a child under 19 years of age, the insurer must pay a monthly benefit to each child equal to 4.35 times 25 percent of the state average weekly wage, subject to the following:¶
(a) Total monthly benefits paid under this section must not exceed 4.35 times 133-1/3 percent of the state average weekly wage. If the sum of the individual benefits exceeds this maximum, the insurer must reduce the benefit for each child proportionally;¶
(b) The insurer may make payment of benefits due under this section to the child's parent, legal guardian, or person having custody of the child. If the child becomes sui juris, the insurer must begin making payment of benefits directly to the child immediately upon the child's written request; and¶
(c) The insurer must send each child Form 5332, "Notice to Beneficiary of Entitlement to Benefits" at least 90 days before their 18th birthday, informing the child of their right to receive benefit payments directly under subsection (b), and of their entitlement to higher education benefits.¶
(5) Benefit to surviving dependent. If a worker is survived by a dependent, the insurer must pay a monthly benefit to each dependent that is equal to 50 percent of the average monthly support the dependent actually received from the worker during the 12 months preceding the occurrence of the accidental injury, subject to the following:¶
(a) Payments to the dependent must continue until:¶
(A) The dependent becomes 19 years of age, if the dependent is under the age of 19 years at the time of the accidental injury; or¶
(B) The time the dependency would have terminated had the injury not happened, if the dependent is 19 years of age or older at the time of the accidental injury;¶
(b) Within five business days after the date of receipt of a request for benefits from an eligible dependent, the insurer must mail the dependent a request for verifiable documentation of the support the dependent actually received from the worker during the 12 months preceding the occurrence of the accidental injury. The request must:¶
(A) Inform the dependent what verifiable documentation the dependent must submit to the insurer to calculate the dependent's benefit; and¶
(B) Clearly state that if the insurer does not receive the required documentation within 60 days of the mailing date of the request, the insurer will determine the dependent's monthly benefit based only on the information in the insurer's possession;¶
(c) Upon receipt of verifiable documentation or the expiration of the 60-day period in paragraph (5)(b)(B) of this rule, the insurer must:¶

(A) Determine the dependent's monthly benefit and begin payment under OAR 436-060-0150(6); or¶
(B) Notify the dependent that the information in the insurer's possession was not sufficient to determine the dependent's monthly benefit and provide information about how the dependent may appeal this decision; and¶
(d) As used in this section, "verifiable documentation" means any written record of financial support provided to the dependent by the worker including, but not limited to, receipts, billing statements, bank account statements, or signed affidavits.¶
(6) Benefit to child or dependent attending higher education. The insurer must pay up to 48 months of benefits during any period in which an eligible child or dependent is between the ages of 19 and 26 and is completing secondary education, is obtaining a general educational development certificate, or is attending a program of higher education, including vocational or technical training.¶
(a) Benefits under this section must be paid for an entire month. The child or dependent may claim a full month's benefit for any month in which the child is completing secondary education, obtaining a general educational development certificate, or attending a program of higher education for at least one day.¶
(b) The child or dependent must provide the insurer with documentation that enables the insurer to determine the child's or dependent's eligibility for monthly benefits.¶
(A) As used in this section, "documentation" includes, but is not limited to, verification of enrollment in a secondary school, general education development certificate program, or program of higher education.¶
(B) The child or dependent may use Form 5332, "Notice to beneficiary of entitlement to benefits," to satisfy the requirements of this section.¶
(7) Death during permanent total disability. If a worker dies during a period of permanent total disability:¶
(a) The insurer must pay the costs of final disposition of the body and funeral expenses in the same manner and same amounts as provided in section (1) of this rule, subject to the following:¶
(A) For claims with a date of injury before July 1, 1973, burial benefits are due only if death results from the accidental injury causing the permanent total disability; and¶
(B) For claims with a date of injury on or after July 1, 1973:¶
(i) Burial benefits are due if death results from the accidental injury causing the permanent total disability; or¶
(ii) Burial benefits are due regardless of the reason for death, if the worker was survived by an eligible beneficiary;¶
(b) ~~The insurer must pay benefits to surviving beneficiaries in the same manner and same amounts as provided in sections (2) through (6) of this rule:¶~~
~~(A) Permanent total disability benefits must be paid through the date of death. Benefits under this section begin to accrue the following calendar day; and¶~~
~~(B) Benefits payable for a partial month must be calculated by dividing the monthly benefit by the actual number of days in the month and multiplying that result by the number of days payable;¶~~
~~(c~~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 benefits under this section begin to accrue the calendar day after the date of death; ¶
(d) The insurer is not required to reopen and close the claim to begin making payments under this section; and¶
(~~d~~e) 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/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.204, ORS 656.208, ORS 656.268(14)

AMEND: 436-060-0095

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: OAR 436-060-0095 is amended to:

-Remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.

CHANGES TO RULE:

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/Other Authority: ORS 656.325, ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.325, ORS 656.704, ORS 656.726(4)

AMEND: 436-060-0105

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: OAR 436-060-0105 is amended to remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.

CHANGES TO RULE:

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/Other Authority: ORS 656.325, ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.325, ORS 656.704, ORS 656.726(4)

AMEND: 436-060-0135

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: OAR 436-060-0135 is amended to remove obsolete mandatory notice language that is no longer in effect as of Oct. 1, 2024.

CHANGES TO RULE:

436-060-0135
Injured Worker, Workers 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/Other Authority: ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.704, ORS 656.726(4), ORS 656.262

AMEND: 436-060-0137

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: 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.

CHANGES TO RULE:

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 ~~to~~by requesting a hearing by the board within 60 days of the order.¶
(d) For purposes of determining the number of insurer required vocational evaluations, any evaluations scheduled but not completed are not counted as a statutory vocational evaluation.¶
(3) Notice to worker. The insurer must notify the worker of the evaluation at least 10 days before the date of evaluation.¶
(a) The notice sent for each evaluation, including evaluations that have been rescheduled, must contain the following:¶
(A) The name of the vocational assistance provider or facility;¶
(B) A statement of the specific purpose for the evaluation;¶
(C) The date, time and place of the evaluation;¶
(D) The first and last name of the attending physician or authorized nurse practitioner or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;¶
(E) If applicable, confirmation that the director has approved the evaluation;¶
(F) Notice to the worker that the reasonable cost of public transportation or use of a private vehicle will be reimbursed; when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed; a request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request; should an advance of costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance; and¶
(G) The following notice:~~¶~~
~~(i) In prominent or bold text:¶~~
~~"You must attend this vocational evaluation. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the evaluation. If you do not attend or do not cooperate, or do not have a good reason for not attending, your compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.206 and OAR 436-060. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or the Ombuds Office for Oregon Workers at 1-800-927-1271."¶~~

~~(ii) Effective no later than Oct. 1, 2024, the text in (G)(i) of this subsection must be replaced with the following language~~ in bold and formatted as follows:¶
You must attend this evaluation. ¶
¶
If there is any reason you cannot attend, you must tell us as soon as possible before the date of the evaluation. ¶
¶
Your workers' compensation benefits may be suspended under Oregon laws and rules* if you: ¶
¶
- Do not attend the evaluation, ¶
- Do not cooperate with the evaluation, or ¶
- Do not have good reason for not attending. ¶
¶
If you have any questions you may call: ¶
- [Insurer] at [Insurer phone number] ¶
- Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585 ¶
- Ombuds Office for Oregon Workers at 800-927-1271 (toll-free). ¶
¶
*Oregon Revised Statute 656.206 and Oregon Administrative Rules Chapter 436, division 60¶
(b) The insurer may contract with a third party to schedule vocational evaluations. If the third party notifies the worker of a scheduled evaluation on behalf of the insurer, the third party must send the notice on the insurer's stationery and the notice must meet the requirements of this section.¶
(4) Reimbursements of costs. The insurer must pay the costs of the vocational evaluation and related services necessary to allow the worker to attend the evaluation, including a reasonable cost of public transportation or use of a private vehicle, and when necessary, a reasonable cost of child care, meals, lodging and other related services. Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, comply with this rule.¶
(5) Suspension of compensation. When the worker refuses or fails to attend, or otherwise obstructs, a vocational evaluation reasonably requested by the insurer or the director, the director may suspend the worker's compensation by order, under the following conditions:¶
(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/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.206

AMEND: 436-060-0140

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: 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.

CHANGES TO RULE:

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/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.726(4), 656.262, 656.325

REPEAL: 436-060-0141

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: OAR 436-060-0141 is repealed.

CHANGES TO RULE:

~~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/Other Authority: ORS 656.726(4)~~
~~Statutes/Other Implemented: ORS 656.262, 656.745~~

AMEND: 436-060-0155

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: OAR 436-060-0155 is amended to change when a penalty payment following a stipulation is due.

CHANGES TO RULE:

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 of the proceedings 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. [See attached table.]¶
(c) ~~P~~Notwithstanding (5) of this rule, payment of a penalty due under this section ~~is due within 14~~must be paid within five business days ~~after~~of the date the director's order approv~~es~~ing the stipulation~~, unless otherw~~ becomes final, unless a different payment date is~~e~~ 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/Other Authority: ORS 656.262(11), 656.704, 656.726(4), 656.745
Statutes/Other Implemented: ORS 656.262(11), 656.704, 656.745

AMEND: 436-060-0200

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: OAR 436-060-0200 is amended to remove and update provisions related to civil penalties, performance audits, and considerations for assessing penalties.

CHANGES TO RULE:

436-060-0200
Assessment of Civil Penalties ¶

(1) Penalties for inducing failure to report claims. The director will assess a civil penalty under ORS 656.745(1) against an employer or insurer that intentionally or repeatedly induces workers to fail to report accidental injuries, causes employees to collect accidental injury claims as off-the-job injury claims, persuades workers to accept less than the compensation due or makes it necessary for workers to resort to proceedings against the employer to secure compensation due. For the purpose of this section:¶
(a) "Intentionally" means the employer or insurer acted with a conscious objective to engage in the conduct or cause any result described in this section; and¶
(b) "Repeatedly" means more than once in any 12-month period.¶
(2) Penalties for failure to comply with statutes, rules, and orders. The director may assess a civil penalty under ORS 656.745(2) against an employer or insurer that violates ORS chapter 656, OAR chapter 436, or orders of the director regarding reports or other requirements necessary to carry out the purposes of ORS chapter 656. Except as provided in ORS 656.780, the director may assess a civil penalty against a service company only for claims processing violations identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an employer, insurer, or service company identified in an annual audit.¶
(3) ~~Penalties for failure to meet time frame requirements. The director may assess a civil penalty under ORS 656.745(2) against an employer or insurer that does not meet the time frame requirements in OAR 436-060-0010, 436-060-0011, 436-060-0017, 436-060-0018, 436-060-0030, 436-060-0060, 436-060-0140, 436-060-0147, 436-060-0155 and 436-060-0180. The director may assess a civil penalty under ORS 656.745(2) against a service company that does not meet the time frame requirements, only for violations identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an employer, insurer, or service company identified in an annual audit.¶~~
~~(4) Penalties for use of sight draft to pay compensation. The director may assess a civil penalty under ORS 656.745(2) against an insurer that willfully violates OAR 436-060-0160.¶~~
~~(5) Penalties for inaccurate reporting of first payment timeliness. The director may assess a civil penalty under ORS 656.745(2) against an insurer that does not accurately report timeliness of first payment information to the division. The director may assess this civil penalty against the service company processing the insurer's claims if the violations were identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an insurer or service company identified in an annual audit. For the purposes of this section, a violation consists of each situation in which a first payment was reported to have been made timely, but was found upon audit to have actually been late.¶~~
~~(6) Penalties for failure to comply with claims processing requirements. Notwithstanding section (3) of this rule, the director may assess civil penalties under ORS 656.745(2) against an employer, insurer, or service company for each violation of the claims processing requirements of ORS chapter 656, OAR chapter 436, or orders of the director. For the purpose of this section, the statutory claims processing requirements include but are not limited to, ORS 656.202, 656.210, 656.212, 656.228, 656.234, 656.236, 656.245, 656.262, 656.263, 656.264, 656.265, 656.268, 656.273, 656.307, 656.313, 656.325, and 656.331.¶~~
~~(7)~~ Penalties for misrepresentation to obtain claims records. The director may assess a civil penalty of $1,000 against any employer or insurer that misrepresents itself in any manner to obtain workers' compensation claims records from the director, or that uses such records in a manner contrary to these rules. In addition, the director may suspend or revoke:¶
(a) An employer's or insurer's access to workers' compensation claims records for such time as the director may determine; or¶
(b) Any other person's access to workers' compensation claims records if the director determines they have misrepresented themselves or used records in a manner contrary to these rules.¶
(~~8~~4) 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 s~~et 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~~pecified for audits.¶
(~~10~~5) 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/Other Authority: ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.704, ORS 656.726(4), ORS 656.202, ORS 656.210, ORS 656.212, ORS 656.228, ORS 656.234, ORS 656.236, ORS 656.245, ORS 656.262, ORS 656.263, ORS 656.264, ORS 656.265, ORS 656.268, ORS 656.273, ORS 656.307, ORS 656.313, ORS 656.325, ORS 656.331, ORS 656.745

AMEND: 436-060-0500

NOTICE FILED DATE: 10/29/2025

RULE SUMMARY: 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.

CHANGES TO RULE:

436-060-0500
Reimbursement of Supplemental Disability for Workers with Multiple Jobs at the Time of Injury ¶

(1) General. When an insurer elects to pay supplemental disability due a worker with multiple jobs at the time of injury, the director will reimburse the supplemental amount quarterly, after receipt and approval of documentation of compensation paid by the insurer or service company. The director will reimburse the insurer, in care of the service company, if applicable.¶
(2) Requests for reimbursement. Requests for reimbursement must be submitted on Form 3504, "Supplemental Disability Benefits Quarterly Reimbursement Request," and must include at least:¶
(a) Identification and address of the insurer responsible for processing the claim;¶
(b) The worker's name, WCD file number, date of injury, Social Security number (if known), and the insurer claim number;¶
(c) Whether the claim is disabling or nondisabling;¶
(d) The primary and secondary employers' legal names;¶
(e) The primary and secondary employers' policy numbers;¶
(f) The weekly wage of all jobs at the time of the injury separated by employer;¶
(g) The start and end dates for the periods of supplemental disability due and payable to the worker;¶
(h) The amount of supplemental disability paid for the periods in subsection (g);¶
(i) The quarter and year in which the payment was made;¶
(j) A signed payment certification statement verifying the payments; and¶
(k) Any other information the director requires.¶
(3) Administrative fee. In addition to the supplemental disability reimbursement, the director will pay the insurer an administrative fee based on the annual claim processing administrative cost factor, as published in Bulletin 316.¶
(4) Repayment of invalid or incorrect payments. The director may require the insurer to repay reimbursements made for invalid or incorrect payments. An invalid or incorrect payment may be identified at any time, including during an audit by the director, or when the insurer or assigned processing administrator identifies that supplemental disability benefits have been overpaid.¶
(a) The director may periodically audit the insurer's files to validate the amount reimbursed.¶
(b) Invalid amounts include, but are not limited to:¶
(A) Payments exceeding statutory amounts due to the insurer, excluding reasonable overpayments, as determined by the director;¶
(B) Compensation paid as a result of untimely or inaccurate claims processing;¶
(C) Payments of compensation that were not documented as required by OAR 436-050; or¶
(D) Amounts in a third-party recovery that result in overpayment.¶
(5) Benefits due workers of a noncomplying employer. Supplemental disability benefits due subject workers of a noncomplying employer as defined in ORS 656.052 are not eligible for separate reimbursement under this rule, but remain a cost recoverable from the employer as provided by ORS 656.054(2).¶
(6) Claim disposition agreements ~~and stipulated claims settlement~~, disputed claim settlements, and settlement stipulations. Claim dispositions agreements ~~or stipula~~under ORS 656.236, disputed claims settlements~~,~~ under ORS 656.23~~689~~, or ~~656.289~~other settlement stipulations regarding matters under ORS chapter 656, 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.¶
(~~b~~c) 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/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.210

AMEND: 436-075-0030

NOTICE FILED DATE: 10/29/2025

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

CHANGES TO RULE:

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) ~~B~~Except as specified in OAR 436-060-0075(7), 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/Other Authority: ORS 656.506, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.206 [OL 2017, ch. 70], ORS 656.209, ORS 656.506