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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

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RULES:
436-030-0015, 436-030-0020, 436-030-0035, 436-060-0015, 436-060-0018, 436-060-0020, 436-060-0095, 436-060-0137, 436-060-0147, 436-060-0170, 436-120-0012, 436-120-0443

AMEND: 436-030-0015

NOTICE FILED DATE: 10/28/2022

RULE SUMMARY: Rule 0015 is amended to:
- Update the name of the Ombudsman for Injured Workers to the Ombuds Office for Oregon Workers when an "Updated Notice of Acceptance and Closure" is sent to the estate of a worker after an instant fatality;
- Require that notice to the worker after the claim qualifies for closure must advise the worker that any temporary disability “currently being paid” will end soon, to distinguish this notice from the notice required under Enrolled HB 4138 (2022) that informs the worker the reason temporary disability is no longer due and payable; and
- Include in the list of insurer responsibilities the requirement to mail or deliver the notice required under OAR 436-060-0015(8), which is notice of medically stationary status.

CHANGES TO RULE:

436-030-0015
Insurer Responsibility ¶

(1) When an insurer issues a Notice of Closure (Form 1644), the insurer is responsible for:¶
(a) Providing the director, the parties, and the worker's attorney if the worker is represented, a copy of the Notice of Closure, a copy of the Notice of Closure Worksheet (Form 2807) upon which the Notice is based, a completed Insurer Notice of Closure Summary (Form 1503), and an Updated Notice of Acceptance at Closure that specifies which conditions are compensable, as prescribed in OAR 436-030-0020;¶
(b) Maintaining a copy of the worksheet and records upon which the Notice of Closure is based in its claim file for audit purposes under OAR 436-050; and¶
(c) Issuing the Updated Notice of Acceptance at Closure on the same date as the Notice of Closure.¶
(A) The Updated Notice of Acceptance at Closure must contain the following title, information, and language:¶
(i) Title: "Updated Notice of Acceptance at Closure";¶
(ii) Information: A list of all compensable conditions, even if a condition was denied, ordered accepted by litigation,

and is under appeal. Any conditions under appeal and those which were the basis for this claim opening must be specifically identified; and¶
(iii) Language, in bold print:¶
"Notice to Worker: This notice restates and includes all prior acceptances. The conditions that were the basis of this claim opening were the only conditions considered at the time of claim closure. The insurer or self-insured employer is not required to pay any disability compensation for any condition specifically identified as under appeal, unless and until the condition is found to be compensable after all litigation is complete. Appeal of any denied conditions or objections to this notice will not delay claim closure. Any condition found compensable after the Notice of Closure is issued will require the insurer to reopen the claim for processing of that condition. If you believe a condition has been incorrectly omitted from this notice, or this notice is otherwise deficient, you must communicate the specific objection to the insurer in writing.";¶
(B) In the case of an instant fatality, the Updated Notice of Acceptance may be combined with the Notice of Closure if the following is included:¶
(i) Title: "Updated Notice of Acceptance and Closure";¶
(ii) Information: A statement that beneficiaries may be entitled to death benefits under ORS 656.204 and 656.208, and the medically stationary date; and¶
(iii) Language, in bold print:¶
"Notice to Worker's Beneficiary or Estate: This notice restates any prior acceptances. The insurer is required to determine the appropriate benefits to be paid to any beneficiaries and begin those payments within 30 days of the mailing date of this notice.¶
If you disagree with the notice of acceptance, you may appeal the decision to the Workers' Compensation Board, 2601 25th Street SE, Suite 150, Salem, OR 97302-1280 within 30 days of the mailing date.¶
A beneficiary who was mailed this notice may request reconsideration of the notice by the Workers' Compensation Division, Appellate Review Unit, 350 Winter Street NE, PO Box 14480 Salem, OR 97309-0405 within 60 days of the mailing date of this notice.¶
Beneficiaries who were not mailed a copy of this notice may request reconsideration of this notice within one year of the date this notice was mailed to the estate of the worker.¶
If you have questions about this notice, you may contact the Ombuds~~man for Injured~~ Office for Oregon Workers, the Workers' Compensation Division, or consult with an attorney."¶
(C) If the "Initial Notice of Acceptance" is issued at the same time as the "Updated Notice of Acceptance at Closure," both titles must appear near the top of the document.¶
(D) When an omission or error requires correcting an Updated Notice of Acceptance at Closure, the document must be clearly titled "Corrected Updated Notice of Acceptance at Closure." ¶
(2) The insurer or self-insured employer is not required to pay any disability compensation for any condition under appeal and specifically identified as such, unless and until the condition is found to be compensable after all litigation is complete.¶
(3) Copies of Notices of Refusal to Close must be mailed to the director and the parties, and to the worker's attorney, if the worker is represented.¶
(4) In claims with a date of injury on or after January 1, 2005, where the worker has not returned to regular work and ORS 656.726(4)(f) does not apply, or in claims with a date of injury on or after January 1, 2006, when the worker has not been released to regular work and ORS 656.726(4)(f) does not apply, the insurer must consider:¶
(a) The worker's age at the time the notice is issued;¶
(b) Adaptability to return to employment;¶
(c) The worker's level of education; and¶
(d) The worker's work history, including an accurate description of the physical requirements of the worker's job held at the time of injury, for the period from five years before the date of injury to the mailing date of the Notice of Closure with dates or period of time spent at each position, tasks performed or level of specific vocational preparation (SVP), and physical requirements. If the insurer cannot obtain five years of work history despite all reasonable efforts, the insurer must document its efforts and provide as much work history as it can obtain.¶
(5) In claims where the date of injury is before January 1, 2005, the worker has not returned or been released to regular work, ORS 656.726(4)(f) does not apply, and the claim involves injury to, or disease of, unscheduled body parts, areas, or systems, the insurer must consider:¶
(a) The worker's age at time the notice is issued;¶
(b) Adaptability to return to employment:¶
(c) The worker's level of education; and¶
(d) The worker's work history, including an accurate description of the physical requirements of the worker's job held at the time of injury, for the period from five years before the date of injury to the mailing date of the Notice of Closure with dates or period of time spent at each position, tasks performed or level of specific vocational preparation (SVP), and physical requirements.¶

(6) The insurer must consider any other records or information pertinent to claim determination prior to issuing a Notice of Closure.¶
(7) The insurer must notify the worker and the worker's attorney, if the worker is represented, in writing, when the insurer receives information that the worker's claim qualifies for closure under these rules.¶
(a) The insurer must send the written notice within three working days from the date the insurer receives the information, unless the claim has already been closed.¶
(b) The notice must advise the worker of impending claim closure and that any temporary disability ~~payments~~benefits currently being paid will end soon.¶
(8) The insurer must, within 14 days of closing the claim, provide the worker's attorney the same documents relied upon for claim closure.¶
(9) The insurer may not issue a Notice of Closure on an accepted nondisabling claim. Notices of Closure issued by the insurer in violation of this rule are void and without legal effect. Medically stationary status in nondisabling claims may be documented by the attending physician's statement of medically stationary status.¶
(10) When a condition is accepted after a closure and the claim has been reopened under ORS 656.262, the insurer must issue a Notice of Closure, considering only the newly accepted condition.¶
(11) Denials issued under ORS 656.262(7)(b), must clearly identify the phrase "major contributing cause" in the text of the denial.¶
(12) When a claim is closed where a designation of paying agent order (ORS 656.307) has been issued and the responsibility issue is not final by operation of law, the insurer processing the claim at the time of closure must send copies of the closure notice to the worker, the worker's attorney if the worker is represented, the director, and all parties involved in the responsibility issue.¶
(13) Forms 1503, 1644, and 2807 are published with Bulletin 139.¶
(14) The insurer must mail or deliver the notice required under OAR 436-060-0015(8).
Statutory/Other Authority: ORS 656.268 (OL2022, ch. 73, sections 4 & 5), ORS 656.726
Statutes/Other Implemented: ORS 656.268 (OL2022, ch. 73, sections 4 & 5), ORS 656.726, ORS 656.262, ORS 656.331

AMEND: 436-030-0020

NOTICE FILED DATE: 10/28/2022

RULE SUMMARY: Rule 0020 is amended to:

- Update the name of the Ombudsman for Injured Workers to the Ombuds Office for Oregon Workers on the Notice of Closure; and

- For claims closed after the end of an authorized training program, require a current (within 60 days before closure) determination of medically stationary status and residual functional capacity (relevant for work disability); the current rule allows three months.

CHANGES TO RULE:

436-030-0020
Requirements for Claim Closure ¶

(1) Issuance of a Notice of Closure. Unless the worker is enrolled and actively engaged in an authorized training plan under OAR 436-120, the insurer must issue a Notice of Closure on an accepted disabling claim within 14 days when:¶
(a) Medical information establishes that there is sufficient information to determine the extent of permanent disability and indicates that the worker is medically stationary;¶
(b) The compensable injury is no longer the major contributing cause of the worker's combined or consequential condition(s), a major contributing cause denial has been issued, and there is sufficient information to determine the extent of permanent disability;¶
(c) The worker fails to seek medical treatment for 30 days for reasons within the worker's control and the requirements for claim closure under OAR 436-030-0034 have been met;¶
(d) The worker fails to attend a mandatory closing examination for reasons within the worker's control and the requirements for claim closure under OAR 436-030-0034 have been met; or¶
(e) A worker receiving permanent total disability benefits has materially improved and is capable of regularly performing work at a gainful and suitable occupation.¶
(2) Sufficient Information. For purposes of determining the extent of permanent disability, except as provided in section (14) of this rule for closure after training, "sufficient information" requires: a qualifying statement of no permanent disability under subsection (a) of this section or a qualifying closing report under subsection (b) of this section. Additional documentation is required under subsection (c) of this section unless there is clear and convincing evidence that an attending physician or authorized nurse practitioner has released the worker to the job held at the time of injury or that the worker has returned to the job held at the time of injury.¶
(a) Qualifying statements of no permanent disability. A statement indicating that there is no permanent disability is sufficient if it meets all of the following requirements:¶
(A) Qualified providers. An authorized nurse practitioner or attending physician must provide or concur with the statement.¶
(B) Support by the medical record. The statement must be supported by the medical record. If the medical record reveals otherwise, a closing examination and report specified under subsection (b) of this section are required.¶
(C) In initial injury claims. In an initial injury claim, the statement must clearly indicate the following:¶
(i) There is no reasonable expectation of any permanent impairment due to an accepted condition or a direct medical sequela of an accepted condition; and¶
(ii) There is no reasonable expectation of any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted condition or a direct medical sequela of an accepted condition.¶
(D) In new or omitted condition claims. In a new or omitted condition claim, the statement must clearly indicate the following:¶
(i) There is no reasonable expectation of any permanent impairment due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition; and¶
(ii) There is no reasonable expectation of any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.¶
(E) In aggravation claims. In an aggravation claim, the statement must clearly indicate the following:¶
(i) There is no reasonable expectation of any permanent impairment due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition; and¶

(ii) There is no reasonable expectation of any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition.¶
(F) In occupational disease claims. In an occupational disease claim, the statement must clearly indicate the following:¶
(i) There is no reasonable expectation of any permanent impairment due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease; and¶
(ii) There is no reasonable expectation of any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease.¶
(b) Qualifying closing reports. A closing medical examination and report are required if there is a reasonable expectation of permanent disability. A closing report is sufficient if it meets all of the following requirements:¶
(A) Qualified providers. A type A attending physician or a chiropractic physician serving as the attending physician must provide or concur with the closing report.¶
(B) Release to regular work. If the worker has no permanent work restriction and the provider identified in paragraph (A) of this rule has not already clearly established the following information, the closing report must include a statement indicating that:¶
(i) The worker has no permanent work restriction; or¶
(ii) The worker is released, without restriction, to the job held at the time of injury.¶
(C) In initial injury claims. In an initial injury claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:¶
(i) Any permanent impairment due to an accepted condition or a direct medical sequela of an accepted condition; and¶
(ii) Any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted condition or a direct medical sequela of an accepted condition.¶
(D) In new or omitted condition claims. In a new or omitted condition claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:¶
(i) Any permanent impairment due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition; and¶
(ii) Any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.¶
(E) In aggravation claims. In an aggravation claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:¶
(i) Any permanent impairment due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition; and¶
(ii) Any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition.¶
(F) In occupational disease claims. In an occupational disease claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:¶
(i) Any permanent impairment due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease; and¶
(ii) Any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease.¶
(c) Additional documentation. Unless there is clear and convincing evidence that an attending physician or authorized nurse practitioner has released the worker to the job held at the time of injury (for dates of injury on or after January 1, 2006) or that the worker has returned to the job held at the time of injury, all of the following is required:¶
(A) An accurate description of the physical requirements of the worker's job held at the time of injury, which has been provided by certified mail to the worker and the worker's attorney, if any, either before closing the claim or at the time the claim is closed, unless the record clearly establishes the physical requirements of the worker's job held at the time of injury;¶
(B) The worker's wage established consistent with OAR 436-060;¶
(C) The worker's date of birth;¶
(D) Except as provided in OAR 436-030-0015(4)(d), the worker's work history for the period beginning five years

before the date of injury to the mailing date of the Notice of Closure, including tasks performed or level of SVP, and physical demands; and¶
(E) The worker's level of formal education.¶
(3) When determining disability and issuing the Notice of Closure, the insurer must apply all statutes and rules consistent with their provisions, particularly as they relate to major contributing cause denials, worker's failure to seek treatment, worker's failure to attend a mandatory examination, medically stationary status, temporary disability, permanent partial and total disability, and review of permanent partial and total disability.¶
(4) When issuing a Notice of Closure (Form 1644), the insurer must prepare and attach a Notice of Closure Worksheet (Form 2807), as described by bulletin of the director, and an Insurer Notice of Closure Summary (Form 1503).¶
(5) The Notice of Closure (Form 1644) is effective the date it is mailed to the worker and to the worker's attorney if the worker is represented, or to the worker's estate if the worker is deceased, regardless of the date on the Notice itself.¶
(6) The Notice of Closure (Form 1644) must be in the form and format prescribed by the director in these rules and include only the following:¶
(a) The worker's name, address, and claim identification information;¶
(b) The appropriate dollar value of any individual scheduled or unscheduled permanent disability based on the value per degree for injuries occurring before January 1, 2005 or, for injuries occurring on or after January 1, 2005, the appropriate dollar value of any "whole person" permanent disability, including impairment and work disability as determined appropriate under OAR 436-035;¶
(c) The body part(s) awarded disability, coded to the table of body part codes as prescribed by the director;¶
(d) The percentage of loss of the specific body part(s), including either the number of degrees that loss represents as appropriate for injuries occurring before January 1, 2005, or the percentage of the whole person the worker's loss represents as appropriate for injuries occurring on or after January 1, 2005;¶
(e) If there is no permanent disability award for this Notice of Closure, a statement to that effect;¶
(f) The duration of temporary total and temporary partial disability compensation;¶
(g) The date the Notice of Closure was mailed;¶
(h) The medically stationary date or the date the claim statutorily qualifies for closure under OAR 436-030-0035 or 436-030-0034;¶
(i) The date the worker's aggravation rights end;¶
(j) The appeal rights of the worker and any beneficiaries;¶
(k) A statement that the worker has the right to consult with the Ombuds~~man for Injured~~ Office for Oregon Workers;¶
(l) For claims with dates of injury before January 1, 2005, the rate in dollars per degree at which permanent disability, if any, will be paid based on date of injury as identified in Bulletin 111;¶
(m) For claims with dates of injury on or after January 1, 2005, the state's average weekly wage applicable to the worker's date of injury;¶
(n) The worker's return to work status;¶
(o) A general statement that the insurer has the authority to recover an overpayment;¶
(p) A statement that the worker has the right to be represented by an attorney; and¶
(q) A statement that the worker has the right to request a vocational eligibility evaluation under ORS 656.340.¶
(7) The Notice of Closure (Form 1644) must be accompanied by the following:¶
(a) The brochure "Understanding Claim Closure and Your Rights";¶
(b) A copy of summary worksheet Form 2807 containing information and findings that result in the data appearing on the Notice of Closure;¶
(c) An accurate description of the physical requirements of the worker's job held at the time of injury unless it is not required under (2)(a) or (2)(c) of this rule or it was previously provided under (2)(c)(A) of this rule;¶
(d) The Updated Notice of Acceptance at Closure which clearly identifies all accepted conditions in the claim and specifies those which have been denied and are on appeal or which were the basis for this opening of the claim; and¶
(e) A cover letter that:¶
(A) Specifically explains why the claim has been closed (e.g., expiration of a period of suspension without the worker resolving the problems identified, an attending physician stating the worker is medically stationary, worker failure to treat without attending physician authorization or establishing good cause for not treating);¶
(B) Lists and describes enclosed documents; and¶
(C) Notifies the worker about the end of temporary disability benefits, if any, and the anticipated start of permanent disability benefits, if any.¶
(8) A copy of the Notice of Closure must be mailed to each of the following persons at the same time, with each copy clearly identifying the intended recipient:¶

(a) The worker;¶
(b) The employer;¶
(c) The director; and¶
(d) The worker's attorney, if the worker is represented.¶
(9) If the worker is deceased at the time the Notice of Closure is issued:¶
(a) The worker's copy of the notice must be addressed to the estate of the worker and mailed to the worker's last known address.¶
(b) Copies of the notice may be mailed to any known or potential beneficiaries to the worker's estate. If a copy of the notice is mailed to a beneficiary, it must be mailed by both regular mail and certified mail return receipt requested.¶
(10) The worker's copy of the Notice of Closure must be mailed by both regular mail and certified mail return receipt requested.¶
(11) An insurer may use electronically produced Notice of Closure forms if consistent with the form and format prescribed by the director.¶
(12) Insurers may allow adjustments of benefits awarded to the worker under the documentation requirements of OAR 436-060-0170 for the following purposes:¶
(a) To recover payments for permanent disability which were made prematurely;¶
(b) To recover overpayments for temporary disability; and¶
(c) To recover overpayments for other than temporary disability such as prepaid travel expenses where travel was not completed, prescription reimbursements, or other benefits payable under ORS 656.001 to 656.794.¶
(13) The insurer may allow overpayments made on a claim with the same insurer to be deducted from compensation to which the worker is entitled but has not yet been paid.¶
(14) Under ORS 656.268(10), if, after claim closure, the worker becomes enrolled and actively engaged in an authorized training plan under OAR 436-120, the insurer must again close the claim consistent with the following:¶
(a) The claim must be closed when the worker ceases to be enrolled and actively engaged in the training and:¶
(A) The worker is medically stationary;¶
(B) The worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions; or¶
(C) The claim otherwise qualifies for closure under OAR 436-030-0034.¶
(b) If the worker is medically stationary, there must be a current (within ~~three month~~60 days before closure) determination of medically stationary status.¶
(c) For claims with dates of injury on or after January 1, 2005, permanent disability must be redetermined for work disability only. For claims with dates of injury before January 1, 2005, permanent disability must be redetermined for unscheduled disability only.¶
(d) Except for claims closed under ORS 656.268(1)(c), the insurer must have sufficient information to redetermine work disability or unscheduled disability. The requirements in section (2) of this rule regarding sufficient information apply only as necessary for the redetermination, as follows:¶
(A) For claims with dates of injury on or after January 1, 2005, the insurer must have sufficient information to determine work disability under OAR 436-035-0012. An evaluation of the adaptability factor of work disability under OAR 436-035-0012(7) through (13) must be based on a current (within ~~three month~~60 days before closure) medical determination of the worker's residual functional capacity.¶
(B) For claims with dates of injury before January 1, 2005, the insurer must have sufficient information to determine unscheduled disability under OAR 436-035-0008(2). An evaluation of unscheduled disability must be based on a current (within ~~three month~~60 days before closure) medical determination.¶
(15) When, after a claim is closed, the insurer changes or is ordered to change the worker's weekly wage upon which calculation of the work disability portion of a permanent disability award may be based, the insurer must notify the parties and the division of the change and the effect of the change on any permanent disability award. For purposes of this rule, the insurer must complete Form 1502 consistent with the instructions of the director and distribute it within 14 days of the change.
Statutory/Other Authority: ORS 656.268~~,~~ (OL2022, ch. 73, sections 4 & 5), ORS 656.726
Statutes/Other Implemented: ORS 656.268~~,~~ (OL2022, ch. 73, sections 4 & 5), ORS 656.726, ORS 656.210, ORS 656.212, ORS 656.214, ORS 656.745

AMEND: 436-030-0035

NOTICE FILED DATE: 10/28/2022

RULE SUMMARY: Rule 0035 is amended to:

- Specify that a physician or nurse practitioner may not retroactively determine a worker to be medically stationary more than 60 days prior to the date of the determination, except in the case of claims that are subject to ORS 656.268(13); and

- Provide that if the medically stationary date under section (1), (4), (5), or (6) of rule 0035 is more than 60 days prior to the date of the determination, the medically stationary date is the 60th day prior to the date of the determination.

CHANGES TO RULE:

436-030-0035
Determining Medically Stationary Status ¶

(1) A worker is medically stationary in the following circumstances:¶
(a) In initial injury claims. In an initial injury claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted conditions and direct medical sequelae of accepted conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.¶
(b) In new or omitted condition claims. In a new or omitted condition claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted new or omitted conditions and direct medical sequelae of accepted new or omitted conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.¶
(c) In aggravation claims. In an aggravation claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted worsened conditions and direct medical sequelae of accepted worsened conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.¶
(d) In occupational disease claims. In an occupational disease claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted occupational diseases and direct medical sequela of accepted occupational diseases are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.¶
(2) When there is a conflict in the medical opinions as to whether a worker is medically stationary, more weight is given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and clear and concise reasoning.¶
(3) Where there is not a preponderance of medical opinion stating a worker is or is not medically stationary, deference will generally be given to the opinion of the attending physician. However, in cases where expert analysis is important, deference is given to the opinion of the physician with the greatest expertise in, and understanding of, the worker's medical condition.¶
(4) When there is a conflict as to the date upon which a worker became medically stationary, the following conditions govern the determination of the medically stationary date. The date a worker is medically stationary is the earliest date that a preponderance is established under sections (1) and (2) of this rule. The date of the examination, not the date of the report, controls the medically stationary date.¶
(5) The insurer may request that the attending physician or authorized nurse practitioner concur with or comment on the closing examination when the attending physician or authorized nurse practitioner arranges or refers the worker for a closing examination with another physician. When the insurer closes a claim relying on an independent medical examination to support a preponderance of opinion establishing medically stationary status, before issuing the closure the insurer must request the attending physician or authorized nurse practitioner to concur with or comment on the independent medical examination. A concurrence with another physician's report is an agreement in every particular, including the medically stationary impression and date, unless the physician expressly states to the contrary and explains the reasons for disagreement. Concurrence cannot be presumed in the absence of the attending physician's response.¶
(6) A worker is medically stationary on the date so specified by a physician. When a specific date is not indicated, a worker is presumed medically stationary on the date of the last examination, prior to the date of the medically stationary opinion. Physician projected medically stationary dates cannot be used to establish a medically stationary date.¶
(7) If the worker is incarcerated or confined in some other manner and unable to freely seek medical treatment, the insurer must arrange for closing medical examinations to be completed at the facility where the worker is

located or at some other location accessible to the worker.¶
(8) If a worker dies and the attending physician has not established a medically stationary date, for purposes of claim closure, the medically stationary date is the date of death.¶
(9) Notwithstanding any other provision of this rule, a physician or nurse practitioner may not retroactively determine a worker to be medically stationary more than 60 days prior to the date of the determination, except in the case of claims that are subject to ORS 656.268 (13). If the medically stationary date under sections (1), (4), (5), or (6) of this rule is more than 60 days prior to the date of the determination, the medically stationary date is the 60th day prior to the date of the determination.
Statutory/Other Authority: ORS 656.268~~,~~ (OL2022, ch. 73, sections 4 & 5), ORS 656.726
Statutes/Other Implemented: ORS 656.268 (OL2022, ch. 73, sections 4 & 5)

AMEND: 436-060-0015

NOTICE FILED DATE: 10/28/2022

RULE SUMMARY: Rule 0015 is amended to:

- Replace a reference to “weekends and legal holidays,” with “Saturday, Sunday, or legal holidays under ORS 187.010 and 187.020” (which are days excluded from the 48 hours allowed for response to worker inquiries);

- Describe the new notice of end of temporary disability benefits required under Enrolled HB 4138 (2022); and

- Describe the new notice of medically stationary status required under Enrolled HB 4138 (2022).

CHANGES TO RULE:

436-060-0015
Required Notice and Information ¶

(1) Notice to worker's attorney. If a worker is represented by an attorney, and the attorney has given written notice of representation, the insurer must provide written notice to the worker's attorney before, or at the same time, as the insurer:¶
(a) Requests the worker to submit to a medical examination;¶
(b) Contacts the worker regarding any matter that may result in denial, reduction, or termination of the worker's benefits; or¶
(c) Contacts the worker regarding any matter relating to the disposition of a claim under ORS 656.236.¶
(2) Penalty for failure to provide notice to worker's attorney. The director may assess a civil penalty against an insurer that intentionally or repeatedly fails to give notice as required under section (1) of this rule.¶
(3) Information provided to worker. The insurer or service company must provide:¶
(a) Form 1138, "What happens if I'm hurt on the job?" to every worker who has a disabling claim with the first disability check or earliest written correspondence. For nondisabling claims, Form 3283, "A Guide for Workers Recently Hurt on the Job," may be provided in place of Form 1138, unless the worker specifically requests Form 1138;¶
(b) Form 3283 to its insured employers. Form 3283 may be printed on the back of Form 801;¶
(c) Form 3058, "Notice to Worker," or an equivalent form, to the worker with the initial notice of acceptance of the claim under OAR 436-060-0140(6). If an equivalent form is provided, it must include all of the information included on Form 3058;¶
(d) The additional notices required under OAR 436-060-0018, 436-060-0030, 436-060-0035, 436-060-0095, 436-060-0105, 436-060-0135, 436-060-0140, and 436-060-0180; and¶
(e) With the first disability check or earliest written correspondence, contact information that will:¶
(A) Reasonably lead the worker to an Oregon certified claims examiner during regular Oregon business hours; and¶
(B) Reasonably ensure that inquiries from the worker are responded to within 48 hours, not including ~~weekends or legal holidays~~Saturday, Sunday, or legal holidays under ORS 187.010 and 187.020.¶
(4) Notice of change of processing location. When the insurer changes claims processing locations, service companies, or self-administration, the insurer must provide at least 10 days prior notice to workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, email address, and mailing address of the new claim processor.¶
(5) Notice of change in rate of compensation and benefit amounts. When the insurer changes the rate of compensation, the wage used to calculate benefit amounts, or the method of calculation used to determine benefits, the insurer must provide a written explanation of any change to the worker and the worker's attorney, if any.¶
(6) Notice of wage used to calculate benefits at closure. Before closure of a disabling claim the insurer must send a notice to the worker that:¶
(a) Documents the wage upon which benefits were based;¶
(b) Informs the worker that work disability, if applicable, will be determined when the claim is closed; and¶
(c) Explains how the worker can appeal the insurer's wage calculation if the worker disagrees with the wage.¶
(7) Notice of end of temporary disability benefits. In addition to other requirements in OAR chapter 436, the insurer may not end temporary disability benefits until written notice has been mailed or delivered to the worker and the worker's attorney, if the worker is represented. The notice must state the reason that temporary disability benefits are no longer due and payable.¶
(8) Notice of medically stationary status. An insurer must mail or deliver a written notice to a worker and the worker's attorney, if the worker is represented, within seven days following receipt of information that the worker

is medically stationary.
Statutory/Other Authority: ORS 656.331, ORS 656.726(4), ORS 656.745
Statutes/Other Implemented: ORS 656.331, ORS 656.726(4), ORS 656.745, ORS 656.262 (OL2022, ch. 73, sections 1 & 2), ORS 656.268 (OL2022, ch. 73, sections 4 & 5)

AMEND: 436-060-0018

NOTICE FILED DATE: 10/28/2022

RULE SUMMARY: Rule 0018 is amended to update the name of the Ombudsman for Injured Workers to the Ombuds Office for Oregon Workers for written notices regarding reclassification.

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 the following statement, in bold print:¶
"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~~man for Injured~~ Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)."¶
(c) If the worker disagrees with the insurer's decision in the Notice of Refusal to Reclassify, the worker may appeal to the director under section (7) of this rule:¶
(A) The appeal must be made no later than the 60th day after the mailing date of the Notice of Refusal to Reclassify; and¶
(B) A copy of the insurer's Notice of Refusal to Reclassify must be provided to the director.¶
(d) If the insurer does not respond to the worker's request for reclassification within 14 days of receipt of the worker's request:¶
(A) The worker may request review by the director under section (7) of this rule as if the insurer issued a Notice of Refusal to Reclassify;¶
(B) The director may assess civil penalties under OAR 436-060-0200; and¶
(C) The director may assess an attorney fee under ORS 656.386(3).¶

(e) If the worker is represented by an attorney, and the attorney is instrumental in obtaining an order from the director that reclassifies the claim from nondisabling to disabling, the director may order a reasonable assessed attorney fee under ORS 656.277 and OAR 436-001-0435.¶
(4) Time frame for aggravation rights. A claim for aggravation under ORS 656.273 must be filed within five years after:¶
(a) The first valid closure of a claim that is reclassified from nondisabling to disabling within one year from the date of acceptance; or¶
(b) The date of injury of a claim that is not reclassified from nondisabling to disabling within one year from the date of acceptance.¶
(5) Claims for aggravation on nondisabling claims. When a claim has been classified as nondisabling for at least one year after the date of acceptance, a worker who believes the claim was or has become disabling may submit a claim for aggravation under ORS 656.273.¶
(6) Reclassification of a disabling claim. If a claim has been accepted and classified as disabling:¶
(a) All aspects of the claim are classified as disabling and may not be reclassified, unless:¶
(A) The claim has been classified as disabling for less than one year from date of acceptance;¶
(B) The insurer determines the criteria for a disabling claim were never satisfied; and¶
(C) The insurer has notified the worker and the worker's attorney, if any, by issuing a Modified Notice of Acceptance. The Modified Notice of Acceptance must include the following:¶
"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~~man for Injured~~ Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)."¶
(b) Any subsequently accepted conditions or aggravations must be processed as disabling claims; and¶
(c) Claim closure must be processed under ORS 656.268.¶
(7) Appeal of insurer's classification decision. If a worker disagrees with an insurer's decision to not reclassify the worker's claim from nondisabling to disabling, the worker may appeal the decision by requesting review by the director:¶
(a) The request must be submitted to the division by mail, hand-delivery, fax, or phone within 60 days from the date of the insurer's notice;¶
(b) The worker may use Form 2943, "Worker Request for Claim Classification Review," for requesting review of the insurer's claim classification decision; and¶
(c) The worker does not need to be represented by an attorney to appeal the insurer's reclassification decision under section (3) or (6) of this rule. If a worker appeals an insurer's reclassification decision:¶
(A) The worker's appeal must be copied to the insurer;¶
(B) The director will acknowledge receipt of the appeal in writing to the worker, the worker's attorney, if any, and the insurer, and initiate the review;¶
(C) Within 14 days of the director's acknowledgement:¶
(i) The insurer must provide the director and all other parties with the complete medical record and all official actions and notices on the claim. The director may impose penalties against an insurer under OAR 436-060-0200 if the insurer fails to provide claim documents in a timely manner; and¶
(ii) The worker may submit any additional evidence for the director to consider. Copies must be provided to all other parties at the same time; and¶
(D) After receipt and review of the required documents, the director will issue an order:¶
(i) The worker and the insurer have 30 days from the mailing date of the order to appeal the director's decision to the board; and¶
(ii) The director may reconsider, abate, or withdraw any order before the order becomes final by operation of law.
Statutory/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: 10/28/2022

RULE SUMMARY: Rule 0020 is amended to replace the requirement to send the worker an explanation for stopping temporary disability payments in place of a scheduled payment with direction that the insurer may not end temporary disability benefits until written notice has been mailed or delivered under OAR 436-060-0015(7) (regarding end of temporary disability).

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 ~~stop~~not end temporary disability ~~payments and, in place of the scheduled payment, must send the worker an explanation for stopping the temporary disability payments~~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 the following notice, in prominent or bold face type:¶
"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)."¶
(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 the following notice, in prominent or bold face type:¶
"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."¶
(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; (OL2022, ch. 73, sections 1 & 2), ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.262; (OL2022, ch. 73, sections 1 & 2), ORS 656.210, ORS 656.212, ORS 656.307

AMEND: 436-060-0095

NOTICE FILED DATE: 10/28/2022

RULE SUMMARY: Rule 0095 is amended to:

- Explain that the director may impose a monetary penalty against the worker under OAR 436-010-0265; and
- Update the name of the Ombudsman for Injured Workers to the Ombuds Office for Oregon Workers for written notice regarding an independent medical exam.

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; and¶
(d) 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 in prominent or bold face type:¶
"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~~man for Injured~~ Office for Oregon Workers at 1-800-927-1271."¶
(e) 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."¶
(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 in prominent or bold face type:¶
"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. If the division grants this request, you may lose all or part of your benefits. If your claim has not yet been accepted, your future benefits, if any, will be jeopardized."¶
(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: 436-060-0137

NOTICE FILED DATE: 10/28/2022

RULE SUMMARY: Rule 0137 is amended to update the name of the Ombudsman for Injured Workers to the Ombuds Office for Oregon Workers for written notice regarding a vocational evaluation.

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 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 in prominent or bold face type:¶
"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~~man for Injured~~ Office for Oregon Workers at 1-800-927-1271."¶
(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 in prominent or bold face type:¶
"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. If the division grants this request, you may lose all or part of your benefits."¶
(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: 436-060-0147

NOTICE FILED DATE: 10/28/2022

RULE SUMMARY: Rule 0147 is amended to update the name of the Ombudsman for Injured Workers to the Ombuds Office for Oregon Workers as a consultation resource for unrepresented workers who have questions about worker-requested medical exams.

CHANGES TO RULE:

436-060-0147
Worker Requested Medical Examination ¶

(1) Eligibility. The worker is eligible for a worker requested medical examination if:¶
(a) The worker has made a timely request for a board hearing on a denial of compensability;¶
(b) The denial is based on one or more independent medical examination reports; and¶
(c) The attending physician or authorized nurse practitioner does not concur with the report or reports.¶
(2) Request for exam. The worker must submit a request for the exam to the division. A copy of the request must be sent simultaneously to the insurer.¶
(a) The request must include:¶
(A) The name, address, and claim identifying information of the worker;¶
(B) A list of physicians, including names and addresses, who have previously provided medical services to the worker on the claim, or who have previously provided medical services to the worker related to the claimed conditions;¶
(C) The date the worker requested a hearing and a copy of the hearing request;¶
(D) A copy of the insurer's denial letter; and¶
(E) Documents that demonstrate that the attending physician or authorized nurse practitioner does not concur with the independent medical examination report or reports, if available.¶
(b) The director will determine the worker is eligible for an exam if the eligibility criteria in section (1) of this rule are met and:¶
(A) The worker or insurer provides documents that demonstrate that the attending physician or authorized nurse practitioner does not concur with the independent medical examination report or reports; or¶
(B) The director has not received documents that demonstrate the attending physician or authorized nurse practitioner does or does not concur with the report or reports, and at least 30 days after the worker's request for hearing under subsection (1)(a) of this rule have passed.¶
(3) Required documentation. The insurer must send to the director no later than the 14th day following the insurer's receipt of the worker's request, the names and addresses of all physicians or nurse practitioners who have:¶
(a) Acted as the worker's attending physician or authorized nurse practitioner;¶
(b) Provided medical consultations or treatment to the worker;¶
(c) Examined the worker at an independent medical examination requested by the insurer under ORS 656.325; or¶
(d) Reviewed the worker's medical records on the claim.¶
(4) Penalty for failure to provide documentation. Failure to provide the required documentation described in section (3) of this rule in a timely manner may subject the insurer to civil penalties under OAR 436-060-0200.¶
(5) Selection of physicians. If the director determines the worker is eligible for the exam, the director will notify all parties in writing of the physician selected, or will provide the worker or the worker's attorney a list of appropriate physicians. If the director provides a list of physicians, the following applies:¶
(a) The worker's or the worker's attorney's response must be in writing, signed, and delivered to the director within 14 days of the mailing date of the list;¶
(b) The worker or the worker's attorney may eliminate the name of one physician from the list;¶
(c) If the worker or the worker's attorney does not respond as provided in this section, the director will select a physician; and¶
(d) The director will notify the parties in writing of the physician selected.¶
(6) Scheduling the exam. The worker or the worker's attorney must schedule the exam with the selected physician, and notify the insurer and the board of the scheduled exam date within 14 days of the date of the director's notice in section (5) of this rule. The exam is not required to take place within the 14-day notification period. An unrepresented worker may consult with the Ombuds~~man for Injured~~ Office for Oregon Workers for assistance.¶
(7) Required medical records. The insurer must send the physician the worker's complete medical and diagnostic record on the claim and the original questions asked of the independent medical examination physicians no later

than 14 days before the date of the scheduled exam. If the diagnostic records are not in the insurer's possession, the insurer must request that the medical provider send the diagnostic records to the selected physician at least 14 days before the scheduled exam.¶
(8) Exam questions. The worker, or the worker's attorney, must communicate questions related to the compensability denial in writing to be answered by the physician at the exam to the physician at least 14 days before the scheduled date of the exam. An unrepresented worker may consult with the Ombuds~~man for Injured~~ Office for Oregon Workers for assistance.¶
(9) Physician's response. Upon completion of the exam the physician must address the original independent medical examination questions and the questions from the worker or the worker's attorney under section (8) of this rule and send the report to the worker's attorney, if any, or the worker, and the insurer within 14 days.¶
(10) Payment of physician. The insurer must pay the physician selected under this rule in accordance with OAR 436-009. Medical services to workers must be delivered in accordance with OAR 436-010.¶
(11) Failure to attend exam. If the worker does not attend the scheduled worker requested medical exam, the insurer must pay the physician for the missed exam under OAR 436-009-0010(13). The insurer is not required to pay for another exam unless the worker did not attend the missed examination for reasons beyond the worker's reasonable control.¶
(12) Reimbursement for services. The insurer must reimburse the worker for all necessary related services under ORS 656.325(1).
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.325(1)

AMEND: 436-060-0170

NOTICE FILED DATE: 10/28/2022

RULE SUMMARY: Rule 0170 is amended to update a citation to ORS 656.268, because a new subsection (16) was added by Enrolled House Bill 4138 (2022).

CHANGES TO RULE:

436-060-0170
Recovery of Overpayment of Benefits ¶

(1) Benefits paid a worker. An insurer may only recover overpayment of benefits paid to a worker as specified by ORS 656.268(14) and (16), unless authority is granted by an administrative law judge or the board.¶
(2) Benefits due a worker. An insurer may recover an overpayment from any benefits currently due on any claim the worker has with that insurer. The insurer must explain in writing the reason, the amount, and the method of recovery to the worker and the worker's attorney, if any, or to the worker's beneficiaries.¶
(3) Permanent partial disability offsets. When overpaid benefits are offset against monthly permanent partial disability award payments, the insurer must recover the benefits from the total amount of the award. The insurer must pay out the remainder of the award at 4.35 times the temporary total disability rate, or at least $108.75, starting with the first month's payment.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.268(13),(14), & (16) (OL2022, ch. 73, sections 4 & 5)

AMEND: 436-120-0012

NOTICE FILED DATE: 10/28/2022

RULE SUMMARY: Rule 0012 is amended to update the name of the Ombudsman for Injured Workers to the Ombuds Office for Oregon Workers for notices to workers about vocational assistance.

CHANGES TO RULE:

436-120-0012
General Requirements For Notices and Warnings ¶

(1) Insurer or provider may issue. The insurer is responsible for mailing all notices and warnings required by these rules but may delegate that responsibility to the provider that is providing vocational assistance to the worker. ¶
(2) Required content. All notices and warnings to the worker issued under these rules must:¶
(a) Use the applicable heading. If a notice is used for more than one purpose, it must include all the headings that apply;¶
(b) Be in writing, signed, and dated;¶
(c) State the basis for the decision;¶
(d) Include the effective date of each action in the heading;¶
(e) Cite the relevant rules;¶
(f) Include the worker's appeal rights. All notices and warnings except those notifying a worker of entitlement to training or deferral of vocational assistance eligibility must contain the worker's appeal rights in bold type, as follows:¶
"If you disagree with this decision, you should contact [insert the person's name and the insurer name] within five days of receiving this letter to discuss your concerns. If you are still dissatisfied, you must contact the Workers' Compensation Division within 60 days of receiving this letter or you will lose your right to appeal this decision. A consultant with the division can talk with you about the disagreement and, if necessary, will review your appeal. The address and telephone number of the division are: Employment Services Team, Workers' Compensation Division, P.O. Box 14480, Salem, Oregon 97309-0405; ~~503-947-7816 or~~ 1-800-452-0288."; and¶
(g) Include the telephone number of the Ombuds~~man for Injured~~ Office for Oregon Workers: 1-800-927-1271.¶
(3) Mailing and copies. All notices and warnings must:¶
(a) Be mailed to the worker's last known address by both regular and certified mail; and¶
(b) Be copied to the division and worker's attorney, if any, at the same time the notice or warning is mailed to the worker.¶
(4) Effective date. A notice is not effective until it is sent to all required parties including the worker's attorney.¶
(5) Requirements for warning letters.¶
(a) A warning letter can be issued at any time during the vocational eligibility evaluation or vocational assistance process.¶
(b) Warning letters do not require specific language in the headings but must include a heading clearly indicating the purpose of the warning.¶
(c) A warning letter must state what the worker must do, and by when, to avoid ineligibility or the ending of eligibility or training.
Statutory/Other Authority: ORS 656.340(9), ORS 656.726(4)
Statutes/Other Implemented: ORS 656.340

AMEND: 436-120-0443

NOTICE FILED DATE: 10/28/2022

RULE SUMMARY: Rule 0443 is amended to:

- Require that the insurer may not end temporary disability benefits until written notice under OAR 436-060-0015(7) (regarding end of temporary disability) has been mailed or delivered to the worker and the worker's attorney, if the worker is represented; and
- Update a citation to reflect renumbering within the rule.

CHANGES TO RULE:

436-120-0443
Training - General ¶

(1) Training services include but are not limited to plan development, training, monthly monitoring of training progress, and job placement services.¶
(2) The training plan must be developed and monitored by a counselor.¶
(3) The selection of plan objectives and the kind of training must attempt to minimize the length and cost of training necessary to prepare the worker for suitable employment.¶
(4) If there are any changes made to the original training plan, an addendum to Form 1081, "Training Plan," must be completed, signed by all parties, and submitted to the division.¶
(5) Basic education may be offered, with or without other training components, to raise the worker's education to a level to enable the worker to obtain suitable employment.¶
(6) On-the-job training prepares the worker for permanent, suitable employment with the training employer and for employment in the labor market at large. On-the-job training must be considered first in developing a training plan.¶
(7) Occupational skills training is offered through a community college, based on a predetermined curriculum, at the training employer's location.¶
(8) Formal training may be offered through a vocational school licensed by an appropriate licensing body, community college, or other post-secondary educational facility that is part of a state system of higher education.¶
(9) Rehabilitation facilities training provides evaluation, training, and employment for severely disabled individuals.¶
(10) Notwithstanding OAR 436-120-0145(2)(b), the director may order the insurer, or the insurer may elect, to provide training outside Oregon if such training would be more timely, appropriate, or cost effective than other alternatives.¶
(11) Training status continues during the following breaks:¶
(a) A regularly scheduled break of not more than six weeks between fixed school terms;¶
(b) A break of not more than two weeks between the end of one kind of training and the start of another for which the starting date is flexible; or¶
(c) A period of illness or recuperation of the worker that does not prevent completion of the training by the planned date.¶
(12) The insurer must pay the worker temporary disability compensation, under ORS 656.268 and 656.340, when the worker is actively engaged in an approved training plan and there is a Form 1081, "Training Plan," signed by the worker, the insurer, and the counselor who developed the plan.¶
(13) Temporary disability compensation is limited for each eligibility period to 16 months unless extended to 21 months by the insurer or ordered by the director when the worker provides good cause. Good cause may include but is not limited to the reasons given under section (145) of this rule. In no event may temporary disability compensation during training be paid for more than 21 months.¶
(14) In addition to other requirements in OAR chapter 436, the insurer may not end temporary disability benefits until written notice under OAR 436-060-0015(7) has been mailed or delivered to the worker and the worker's attorney, if the worker is represented.¶
(15) Training costs may be paid for periods longer than 21 months. Reasons for extending training may include but are not limited to:¶
(a) Reasons beyond the worker's control;¶
(b) The worker has an exceptional disability, which is a disability equal to or greater than the complete loss, or loss of use, of both legs, or a brain injury that results in impairment equal or greater than Class 3 as defined in OAR 436-035-0390; or¶

(c) The worker has an exceptional loss of earning capacity, which exists when no suitable training plan of 18 months or less will eliminate the worker's substantial handicap to employment. The extension must allow the worker to obtain, at the time of completion of the training program, a wage that is as close as possible to the worker's adjusted weekly wage and greater than could be expected with a shorter training program.¶
(1~~5~~6) An eligible worker is entitled to four months of job placement assistance after completion of training.¶
(1~~6~~7) When the worker returns to work following training, the insurer must monitor the worker's progress for at least 60 days to assure the suitability of the employment before ending eligibility.¶
(1~~7~~8) If the worker chooses a training plan period longer than the worker is entitled to receive under these rules, the worker may supplement training provided by the insurer by completing self-sponsored training or studies. For the purpose of this rule, self-sponsored means the worker is obligated to pay for the training.¶
(a) The first day of training provided by the insurer will be considered the training start date and the last day of training provided by the insurer will be the training end date.¶
(b) All self-sponsored training must be completed before the training start date unless the parties otherwise agree.¶
(c) During self-sponsored training, the insurer may provide optional services under OAR 436-120-0187, including but not limited to payment of expenses for tuition, fees, books, and supplies.¶
(d) The training plan support document must describe how the worker-sponsored training and the training provided by the insurer will combine to prepare the worker for suitable employment.¶
(1~~8~~9) The insurer must provide further training to a worker if the initial plan will not be or was not successful to prepare the worker for suitable employment.
Statutory/Other Authority: ORS 656.340(9), ORS 656.726(4)
Statutes/Other Implemented: ORS 656.262 (OL2022, ch. 73, sections 1 & 2), ORS 656.340