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CHAPTER 436
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

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RULES:
436-060-0005, 436-060-0010, 436-060-0015, 436-060-0018, 436-060-0020, 436-060-0025, 436-060-0030, 436-060-0060, 436-060-0095, 436-060-0105, 436-060-0135, 436-060-0137, 436-060-0140, 436-060-0150, 436-060-0155, 436-060-0170, 436-060-0180, 436-060-0500

AMEND: 436-060-0005

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0005 is amended to correct a rule citation in section (16).

CHANGES TO RULE:

436-060-0005
Definitions ¶

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made a part of these rules. For the purpose of these rules unless the context requires otherwise:¶
(1) "Aggravation" means an actual worsening of the compensable conditions after the last award or arrangement of compensation that satisfies the requirements of ORS 656.273.¶
(2) "Authorized nurse practitioner" means a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010.¶
(3) "Board" means the Workers' Compensation Board and includes its Hearings Division.¶
(4) "Business days" means Monday through Friday, excluding legal holidays. Legal holidays are those listed in ORS 187.010 and 187.020.¶
(5) "Date stamp" means to stamp or display the initial receipt date and the recipient's name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.¶
(6) "Dependent" means any of the individuals listed under ORS 656.005(10) who, at the time of an accident, depended in whole or in part for support on the earnings of a worker who dies as a result of an injury.¶
(7) "Designated paying agent" means the insurer temporarily ordered responsible to pay compensation for a compensable injury under ORS 656.307.¶
(8) "Director" means the ~~D~~d<u></u>irector of the Department of Consumer and Business Services or the director's designee.¶

(9) "Disposition" or "claim disposition" means the written agreement to release rights or obligations under ORS 656.236.¶
(10) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.¶
(11) "Employer" means a subject employer under ORS 656.023.¶
(12) "Inpatient" means a worker who is admitted to a hospital before and extending past midnight for treatment and lodging.¶
(13) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon; or an employer or employer group certified under ORS 656.430 that meets the qualifications of a self-insured employer under ORS 656.407.¶
(14) "Mailing date," unless otherwise specified, means:¶
(a) The date a document is postmarked;¶
(b) The date automatically produced by electronic transmission (e.g., email or facsimile);¶
(c) The date a hand-delivered document is received by the recipient; or¶
(d) The date of a phone or in-person request, when allowed under these rules.¶
(15) "Physical rehabilitation program" means any services provided to a worker to prevent the compensable injury from causing continuing disability.¶
(16) "Regularly employed" means a worker is receiving a regular wage as defined in section (1~~8~~9) of this rule. For workers who are paid a daily wage, "regularly employed" means actual employment or availability for such employment.¶
(17) "Service company" means the contracted agent for an insurer authorized to process claims and make payment of compensation on behalf of the insurer.¶
(18) "Suspension of compensation" means a period of time where:¶
(a) No temporary disability, permanent total disability, or medical and related service benefits accrue or are payable; and¶
(b) Vocational assistance and payment of permanent partial disability benefits will be stayed.¶
(19) "Wages" is as defined in ORS 656.005(27) and, in these rules, is categorized as either irregular wages or regular wages. Wages do not include expenses incurred due to the job and reimbursed by the employer (e.g., meals, lodging, per diem, equipment rental).¶
(a) "Irregular wages" means a variable pay rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, and it includes but is not limited to:¶
(A) Tips;¶
(B) Commissions;¶
(C) Monies paid on unscheduled or unpredictable intervals, including, but not limited to, workers who are seasonally employed, on call, paid hourly at varying hours, or paid by piece rate; and¶
(D) The reasonable value of any in-kind considerations only if the considerations will not continue during the period of disability~~; and~~.¶
(b) "Regular wages" means a constant and uniform pay rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, and it includes, but is not limited to, wages paid on a daily or weekly basis. Hourly wages may be considered regular if the same number of hours are worked each pay period.¶
(20) "Wage earning agreement" means the verbal or written contract of hiring or terms of employment made between the worker and employer.¶
(21) "Written" means expressed in writing, including electronic transmission.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.726(4), ORS 656.005~~, OL2022, ch. 6, section 5~~

AMEND: 436-060-0010

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0010 is amended to add a new requirement that employers must provide Form 3283 when the nature or extent of the worker's injury is evaluated at an on-site medical service facility.

CHANGES TO RULE:

436-060-0010
Employer Responsibilities ¶

(1) General. A subject employer must accept notice of a claim for workers' compensation benefits from a worker or the worker's attorney under ORS 656.265.¶
(a) Form 801, "Report of Job Injury or Illness," must be readily available for workers to report their injuries. The employer must provide Form 801 to the worker:¶
(A) Immediately upon request by the worker or worker's attorney under ORS 656.265(6); or¶
(B) Upon receiving notice or knowledge of an accident that may involve a compensable injury under ORS 656.262(3)(a).¶
(b) Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims," signed by the worker, is written notice of an accident that may involve a compensable injury. The signed Form 827 will start the claim process, but does not relieve the worker or employer of the responsibility of filing Form 801.¶
(c) Form 3283, "A Guide for Workers Recently Hurt on the Job," may be printed on the back of Form 801, and must be provided by the employer to the worker ~~at the time a~~if any of the following circumstances occur:¶
(A) The worker files a claim for workers' compensation benefits. ~~Form 3283 may be printed on the back of Form 801.~~¶
(B) The worker is evaluated at an on-site medical service facility to assess the nature or extent of a work injury and the employer has notice or knowledge of the work injury. ¶
(d) If a worker provides notice of a claim using an electronic form, the insurer may require the worker to sign a medical release form, so the insurer can obtain medical records necessary to process the claim under OAR 436-010-0240.¶
(2) Employer reporting time frame. An employer, except a self-insured employer, must report a claim to its insurer no later than five days after the date the employer has notice or knowledge of any claim or accident that may result in a compensable injury. The date an employer has knowledge of an accident that may result in a compensable injury is the earliest date any supervisor or manager of the employer has enough facts to reasonably conclude that workers' compensation liability is a possibility.¶
(3) Reporting requirements. The report must provide the information requested on Form 801, and include at least:¶
(a) The worker's name and address;¶
(b) The employer's legal name and address; and¶
(c) The information required under ORS 656.262 and 656.265.¶
(4) Injuries not requiring medical services. The employer is not required to notify the insurer of an accident that does not require the worker to seek treatment from a licensed medical service provider, subject to the following:¶
(a) The employer must report the claim to the insurer under section (2) of this rule, if:¶
(A) The worker chooses to file a claim;¶
(B) The worker signs a Form 801;¶
(C) The worker or employer is billed for treatment; or¶
(D) The employer learns that the injury has resulted in medical services, disability or death. For the purposes of this paragraph, the date of that knowledge under section (2) of this rule is the date the employer received notice or knowledge of the medical services, disability, or death; and¶
(b) If the employer does not give the insurer notice under this section:¶
(A) The employer must maintain records for five years showing the name of the worker, the date of the accident, the nature of the injury and treatment provided; and¶
(B) These records must be available for inspection by the director, the worker or the worker's attorney, if any, and the insurer.¶
(5) Civil penalty for failure to report claims. The director may assess a civil penalty under OAR 436-060-0200 against an employer that:¶
(a) Is late in reporting more than ten percent of its total claims to its insurer during any quarter; or¶
(b) Intentionally or repeatedly pays compensation instead of reporting claims or accidents that may result in a compensable injury to its insurer.¶

(6) Worker's right to choose medical service provider. The worker may choose a medical service provider, attending physician, or authorized nurse practitioner under ORS 656.245, 656.260, OAR 436-010 and 436-015. Except as provided under ORS 656.260 and OAR 436-015, if an employer restricts the worker's choice of medical service provider the director may impose a civil penalty of up to $2,000.
Statutory/Other Authority: ORS 656.265(6), 656.726(4), ORS 656.745
Statutes/Other Implemented: ORS 656.745, 656.245, 656.260, 656.262, 656.265

AMEND: 436-060-0015

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0015 is amended to specify that the notice requirement under section (7) of this rule does not apply to temporary disability benefits paid under ORS 656.210(4), to align with Enrolled Senate Bill 418 (2023).

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 Saturday, Sunday, or legal holidays under ORS 187.010 and 187.020.¶
(4) Notice of change of processing location. When the insurer changes claims processing locations, service companies, or self-administration, the insurer must provide at least 10 days prior notice to workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, email address, and mailing address of the new claim processor.¶
(5) Notice of change in rate of compensation and benefit amounts. When the insurer changes the rate of compensation, the wage used to calculate benefit amounts, or the method of calculation used to determine benefits, the insurer must provide a written explanation of any change to the worker and the worker's attorney, if any.¶
(6) Notice of wage used to calculate benefits at closure. Before closure of a disabling claim the insurer must send a notice to the worker that:¶
(a) Documents the wage upon which benefits were based;¶
(b) Informs the worker that work disability, if applicable, will be determined when the claim is closed; and¶
(c) Explains how the worker can appeal the insurer's wage calculation if the worker disagrees with the wage.¶
(7) Notice of end of temporary disability benefits. In addition to other requirements in OAR chapter 436, the insurer may not end temporary disability benefits until written notice has been mailed or delivered to the worker and the worker's attorney, if the worker is represented. The notice must state the reason that temporary disability benefits are no longer due and payable. This notice requirement does not apply to temporary disability benefits paid under ORS 656.210(4).¶
(8) Notice of medically stationary status. An insurer must mail or deliver a written notice to a worker and the worker's attorney, if the worker is represented, within seven days following receipt of information that the worker is medically stationary.
Statutory/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),~~ ORS 656.268

AMEND: 436-060-0018

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0018 is amended to revise language and formatting of a notice of refusal to reclassify, and a notice of reclassification of a claim to nondisabling status, effective Oct. 1, 2024.

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~~t~~:¶
(i) The following statement, in bold ~~prin~~text:¶
"If you disagree with this Notice of Refusal to Reclassify, you may appeal by contacting the Workers' Compensation Division within sixty (60) days of the mailing date of this notice. You may appeal by using Form 2943, "Worker Request for Claim Classification Review," available on the division's website at wcd.oregon.gov. ¶
Send written appeals to the Workers' Compensation Division, Appellate Review Unit, PO Box 14480, Salem OR 97309-0405 ¶
Or fax to: 503-947-7794¶
Or hand-deliver to: Workers' Compensation Division, Appellate Review Unit, 350 Winter Street NE, 2nd Floor, Salem OR 97301¶
You may appeal by phone by calling the Appellate Review Unit at 503-947-7816. A member of the Appellate Review Unit will complete and sign Form 2943 as the worker's designee and they will send a copy of the completed form to you, the insurer, and any attorneys involved in the claim.¶
If you do not appeal to the Workers' Compensation Division within 60 days of the mailing date of this notice, you will lose all rights to review of this decision. For assistance, you may call the Workers' Compensation Division at 503-947-7816, or the Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)."¶
(ii) Effective no later than Oct. 1, 2024, the statement in (B)(i) of this subsection must be replaced with the following language in bold and formatted as follows:¶
If you disagree with this Notice of Refusal to Reclassify, you may appeal by contacting the Workers' Compensation Division. To appeal: ¶
¶
- Contact the division within 60 days of the mailing date of this notice. ¶
- You may use Form 2943, "Worker Request for Claim Classification Review," available on the division's website at wcd.oregon.gov. ¶
- Request review in writing or by phone. ¶
¶
Send, hand deliver, or fax written requests to: ¶
¶

Workers' Compensation Division ¶
Appellate Review Unit ¶
350 Winter Street NE, 2nd Floor ¶
PO Box 14480 ¶
Salem OR 97309-0405¶
Fax: 503-947-7794¶
¶
Or, call the Workers' Compensation Division at 503-947-7816. The division will complete and sign Form 2943 on your behalf, and will send copies of the completed form to you, the insurer, and any attorneys involved in the claim. ¶
¶
If you do not appeal to the Workers' Compensation Division within 60 days of the mailing date of this notice, you will lose all rights to appeal this decision. ¶
¶
For help, call: ¶
- Workers' Compensation Division at 503-947-7816 ¶
- Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)¶
(c) If the worker disagrees with the insurer's decision in the Notice of Refusal to Reclassify, the worker may appeal 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~~t~~:¶
(i) The following statement in bold text:¶
"Notice to Worker: Your claim has been reclassified to nondisabling. Generally, this means your insurer concluded no disability payments are due and all of the following are true:¶
You were able to return to work at full wages on or before the fourth calendar day after leaving work or losing wages as a result of your injury.¶
You did not lose time or wages from work as a result of your injury on or after that fourth calendar day.¶
It appears you will not have any permanent disability as a result of your injury.¶
If you think there is a mistake in the classification of your claim as nondisabling, contact the insurer within one year of the date the insurer first accepted your claim and request reclassification.¶
If you request reclassification, the insurer must complete its review and send you its decision within 14 days of receiving your request. If you disagree with the insurer's decision, you have the right, within 60 days of the date of the insurer's notice, to request that the Workers' Compensation Division review your claim to determine if it was correctly classified. If the insurer does not respond to your request for reclassification within 14 days of receiving

your request, you may ask the Workers' Compensation Division to review your claim as though the insurer refused to reclassify your claim. For assistance, you may call the Workers' Compensation Division at 503-947-7816, or the Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)."¶
(ii) Effective no later than Oct. 1, 2024, the statement in (C)(i) of this subsection must be replaced with the following language in bold and formatted as follows:¶
Notice to worker: ¶
¶
We have changed your claim to nondisabling. Generally, this means no disability payments are due and all of the following are true: ¶
¶
- You were able to return to work with full wages by the fourth calendar day after leaving work or losing wages because of your injury. ¶
- You did not lose time or wages from work because of your injury on or after that fourth calendar day. ¶
- It appears you will not have any permanent disability because of your injury. ¶
¶
If you disagree that your claim is nondisabling, you may request that we change your claim to disabling. ¶
¶
- You must send us your request in writing within one year of the date we first accepted your claim. ¶
- We must review and send you our decision within 14 days of receiving your request. ¶
¶
If you disagree with our decision, or we do not respond to your request, you have the right to appeal to the Workers' Compensation Division. To appeal: ¶
¶
- You must ask the division to review your claim within 60 days of the date we mailed you our decision. ¶
- If we did not respond within 14 days of receiving your request, ask the division to review your claim as if we refused to change your claim. ¶
¶
For help, call: ¶
- Workers' Compensation Division at 503-947-7816 ¶
- Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)¶
(b) Any subsequently accepted conditions or aggravations must be processed as disabling claims; and¶
(c) Claim closure must be processed under ORS 656.268.¶
(7) Appeal of insurer's classification decision. If a worker disagrees with an insurer's decision to not reclassify the worker's claim from nondisabling to disabling, the worker may appeal the decision by requesting review by the director:¶
(a) The request must be submitted to the division by mail, hand-delivery, fax, or phone within 60 days from the date of the insurer's notice;¶
(b) The worker may use Form 2943, "Worker Request for Claim Classification Review," for requesting review of the insurer's claim classification decision; and¶
(c) The worker does not need to be represented by an attorney to appeal the insurer's reclassification decision under section (3) or (6) of this rule. If a worker appeals an insurer's reclassification decision:¶
(A) The worker's appeal must be copied to the insurer;¶
(B) The director will acknowledge receipt of the appeal in writing to the worker, the worker's attorney, if any, and the insurer, and initiate the review;¶
(C) Within 14 days of the director's acknowledgement:¶
(i) The insurer must provide the director and all other parties with the complete medical record and all official actions and notices on the claim. The director may impose penalties against an insurer under OAR 436-060-0200 if the insurer fails to provide claim documents in a timely manner; and¶
(ii) The worker may submit any additional evidence for the director to consider. Copies must be provided to all other parties at the same time; and¶
(D) After receipt and review of the required documents, the director will issue an order:¶
(i) The worker and the insurer have 30 days from the mailing date of the order to appeal the director's decision to the board; and¶
(ii) The director may reconsider, abate, or withdraw any order before the order becomes final by operation of law.
Statutory/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: 03/27/2024

RULE SUMMARY: Rule 0020 is amended to revise language and formatting of a notice of required medical appointment and a notice of the insurer's suspension of compensation, effective Oct. 1, 2024.

CHANGES TO RULE:

436-060-0020
Payment of Temporary Total Disability Compensation ¶

(1) Employer payment of temporary disability. An employer may pay temporary disability compensation with the approval of the insurer. If the insurer approves an employer to make such payment:¶
(a) The insurer continues to be responsible for determining the worker's entitlement to compensation, and ensuring timely payment of compensation;¶
(b) The employer must provide the insurer with payment documentation that is adequate to meet the insurer's responsibilities; and¶
(c) The insurer must reimburse the employer for any temporary disability compensation paid to the worker under this section.¶
(2) Persons who have withdrawn from the workforce. No temporary disability is due and payable for any period of time in which the person has withdrawn from the workforce. For the purpose of this rule, a person who has withdrawn from the workforce, includes, but is not limited to:¶
(a) A person who, before a claim reopening under ORS 656.267, 656.273 or 656.278, was not working and made no reasonable efforts to obtain employment, unless such efforts would be futile as a result of the compensable injury.¶
(b) A person who was a full-time student for at least six months in the 52 weeks before the date of injury who elects to return to school full time, unless the person can establish a prior customary pattern of working while attending school. For purposes of this subsection, "full time" is defined as twelve or more quarter hours or the equivalent.¶
(3) Authorization of temporary disability compensation. No compensation is due and payable after the worker's attending physician or authorized nurse practitioner ceases to authorize temporary disability, or for any period of time when temporary disability benefits are not authorized by a medical service provider under ORS 656.245(2)(b). Temporary disability compensation is authorized when:¶
(a) The medical service provider provides the insurer or employer with oral or written verification of the worker's inability to work;¶
(b) Documents in the insurer's possession at claim closure reasonably reflect the worker's inability to work. For the purposes of this rule "documents" and "possession" have the same meaning as in OAR 436-060-0017(1); or¶
(c) The director determines, at reconsideration of claim closure, there is sufficient contemporaneous medical documentation to reasonably reflect the worker's inability to work under ORS 656.268.¶
(4) Lack of verification of inability to work. No temporary disability is due and payable for any period of time during which the insurer has requested from the worker's attending physician or authorized nurse practitioner verification of the worker's inability to work and the physician or authorized nurse practitioner cannot verify it, unless the worker has been unable to receive treatment for reasons beyond the worker's control.¶
(a) Before withholding temporary disability under this section, the insurer must ask the worker whether a reason beyond the worker's control prevented the worker from receiving treatment.¶
(A) If no valid reason is found or the worker does not respond or cannot be located, the insurer must document its file regarding those findings.¶
(B) The insurer must provide the director a copy of the documentation within 20 days, if requested.¶
(b) If the attending physician or authorized nurse practitioner is unable to verify the worker's inability to work, the insurer may not end temporary disability benefits until written notice has been mailed or delivered under OAR 436-060-0015(7).¶
(c) When verification of temporary disability is received from the attending physician or authorized nurse practitioner, the insurer must pay temporary disability within 14 days of receiving the verification of any authorized period of temporary disability, unless otherwise denied.¶
(5) Suspension of benefits. An insurer may suspend temporary disability benefits without authorization from the director when all of the following circumstances apply:¶
(a) The worker missed a regularly scheduled appointment with the attending physician or authorized nurse practitioner;¶
(b) The insurer sent a letter by certified mail to the worker and a letter to the worker's attorney, at least 10 days in

advance of a rescheduled appointment, stating that the appointment has been rescheduled with the worker's attending physician or authorized nurse practitioner~~;~~, stating the time and date of the appointment~~;~~, and giving ~~t~~:¶
(A) The following notice, in prominent or bold ~~face type~~text:¶
"You must attend this appointment. If there is any reason you cannot attend, you must tell us before the date of the appointment. If you do not attend, your temporary disability benefits will be suspended without further notice, as provided by ORS 656.262(4)(e)."¶
(B) Effective no later than Oct. 1, 2024, the notice in (b)(A) of this section must be replaced with the following notice in bold and formatted as follows:¶
You must attend this appointment. If there is any reason you cannot attend, you must tell us before the date of the appointment. If you do not attend, your temporary disability benefits will be suspended without further notice under Oregon law.* ¶
¶
If you have any questions you may call: ¶
- [Insurer] at [Insurer phone number] ¶
- Workers' Compensation Division at 800-452-0288 (toll-free) ¶
- Ombuds Office for Oregon Workers at 800-927-1271 (toll-free)¶
¶
*Oregon Revised Statute 656.262(4)(e)¶
(c) The insurer verifies that the worker has missed the rescheduled appointment; and¶
(d) The insurer sends a letter to the worker, the worker's attorney and the division giving the date of the regularly scheduled appointment that was missed, the date of the rescheduled appointment that was missed, the date of the letter being the day benefits are suspended, and ~~t~~:¶
(A) The following notice, in prominent or bold ~~face type~~text:¶
"Since you missed a regular appointment with your doctor, we arranged a new appointment. We notified you of the new appointment by certified mail and warned you that your benefits would be suspended if you failed to attend. Since you failed to attend the new appointment, your temporary disability benefits have been suspended. In order to resume your benefits, you must schedule and attend an appointment with your doctor who must verify your continued inability to work."¶
(B) Effective no later than Oct. 1, 2024, the notice in (d)(A) of this section must be replaced with the following notice in bold and formatted as follows:¶
We have suspended your temporary disability benefits, because you missed a regular appointment with your doctor. ¶
¶
When we arranged a new appointment for [date], we notified you in a letter that was sent by certified mail. ¶
¶
The letter warned you that we would suspend your benefits if you did not attend, and you did not attend the new appointment. ¶
¶
To resume your benefits:¶
- You must schedule and attend an appointment with your doctor, and ¶
- Your doctor must verify that you are still unable to work.¶
(6) Verbal release to work. If temporary disability benefits end because the insurer or employer negotiates a verbal release of the worker to return to any type of work with the worker's attending physician or authorized nurse practitioner, and the worker has not been informed of the release by the attending physician or authorized nurse practitioner or returned to work, the insurer must:¶
(a) Document the facts;¶
(b) Communicate the release to the worker by mail within seven days. The communication to the worker of the negotiated return-to-work release may be contained in an offer of modified employment; and¶
(c) Advise the worker of their reinstatement rights under ORS chapter 659A.¶
(7) Temporary disability from two or more claims. When a worker is due concurrent temporary disability under ORS 656.210 or ORS 656.212 as a result of two or more accepted claims:¶
(a) The director may order one of the insurers to pay the entire amount of temporary disability due; or make a pro rata distribution between two or more of the insurers;¶
(b) The insurers may request for the director to make a pro rata distribution of compensation due. The request must be in writing, and the insurer must provide a copy to the worker and the worker's attorney, if any;¶
(c) The director's pro rata order does not apply to:¶
(A) Any periods of interim compensation payable under ORS 656.262; or¶
(B) Any benefits due under ORS 656.214 or 656.245;¶
(d) Claims subject to the pro rata order must be closed under OAR 436-030 and ORS 656.268, when

appropriate;¶
(e) The pro rata distribution ordered by the director only applies to benefits due as of the date all claims involved are in an accepted status. The order pro-rating compensation will not apply to periods where any claim involved is in a deferred status;¶
(f) The insurers may not prorate temporary disability without the approval of the director, except when the claims involve the same worker, the same employer, and the same insurer. When the insurer prorates temporary disability under this subsection the worker must receive compensation at the highest temporary disability rate of the claims involved.¶
(8) Premature closure. If a closure under ORS 656.268 has been found to be premature and there was an open-ended authorization of temporary disability at the time of closure, the insurer must begin payments under ORS 656.262, including retroactive periods, and pay temporary disability for as long as authorization exists or until there are other lawful bases to terminate temporary disability.¶
(9) Incorrectly denied claims. If a denied claim has been determined to be compensable by final order, the insurer must begin temporary disability payments under ORS 656.262, including retroactive periods, if the authorization for temporary disability was open-ended at the time of denial, and there are no other lawful bases to terminate temporary disability.
Statutory/Other Authority: ORS 656.210(2), ORS 656.245, ORS 656.262 ~~(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: 436-060-0025

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rules 0025 is amended to abbreviate dates cited in the rule.

CHANGES TO RULE:

436-060-0025
Workers Weekly Wage Calculation and Rate of Temporary Disability Compensation ¶

(1) Continuation of wages, insured employers. An employer may not continue to pay wages in place of temporary disability benefits. However, with the worker's consent, the employer may pay the worker amounts in addition to the temporary disability benefits due to the worker, if the employer:¶
(a) Identifies temporary disability benefits separately from other payments; and¶
(b) Does not withhold payroll deductions from the temporary disability benefits.¶
(2) Continuation of wages, self-insured employers. Notwithstanding section (1) of this rule, a self-insured employer may continue to pay the same wage at the same pay interval that the worker received at the time of injury. Such payment qualifies as timely payment of temporary disability under ORS 656.210 and 656.212. If the self-insured employer continues to pay wages in place of temporary disability benefits under this section:¶
(a) Normal deductions including but not limited to, taxes, benefits, and voluntary deductions, must be withheld;¶
(b) The claim must be classified as disabling;¶
(c) The self-insured employer must report to the division the rate and duration of temporary disability that would have been paid had wages not continued; and¶
(d) If the pay interval changes or the amount of wages decreases, the worker must be paid temporary disability as otherwise prescribed by the workers' compensation law.¶
(3) Rate of compensation, generally. Except when payments are made under section (2) of this rule, the worker must receive compensation as calculated under ORS 656.210 during the period of temporary total disability, subject to the following:¶
(a) The benefits of a worker who incurs an injury must be based on the worker's wages at the time of injury and may include regular wages, irregular wages, or both;¶
(b) The benefits of a worker who incurs an occupational disease must be based on the worker's wages at the time there is medical verification the worker is unable to work because of the disability caused by the occupational disease and may include regular wages, irregular wages, or both. If the worker is not working at the time there is medical verification the worker is unable to work because of the disability caused by the occupational disease, the benefits must be based on the worker's wages at the worker's last regular employment;¶
(c) The benefits of a worker who was employed in multiple jobs at the time of injury, and who is eligible for supplemental disability under ORS 656.210(2)(b) and OAR 436-060-0035, must be based on the worker's earnings from all eligible subject employment under OAR 436-060-0035;¶
(d) For a worker with a cyclic schedule, the cycle must be considered to have no scheduled days off; and¶
(e) When a work shift extends into another calendar day, the date of injury used to determine the wage under this section is the date the employer used for payroll purposes.¶
(4) Calculation of irregular wages. If the worker receives irregular wages, the insurer must calculate the worker's irregular wages to determine the worker's average weekly wage based on the weekly average of the worker's irregular wages for the period up to 52 weeks before the date of injury or verification of disability caused by occupational disease, subject to the following:¶
(a) As used in this section:¶
(A) "New wage earning agreement" means the worker's wage earning agreement changed for reasons other than only a pay rate change, including but not limited to a change of hours worked or a change of job duties. A job assignment from a temporary service provider or worker leasing company as defined in OAR 436-180 is not considered to be a new wage earning agreement.¶
(B) "Pay rate change" means an increase or decrease in a previously established pay rate.¶
(b) If, on the date of injury or verification of disability caused by occupational disease, the worker had been employed by the employer at injury for four weeks or more, and the most recent new wage earning agreement had been in place for four weeks or more, the insurer must average the worker's irregular wages for the period up to 52 weeks of employment before the date of injury or verification of disability caused by occupational disease, subject to the following:¶
(A) The insurer must exclude any gap in earnings of more than 14 consecutive calendar days that was not anticipated in the wage earning agreement;¶
(B) If the worker began work under a new wage earning agreement in the 52 weeks before the date of injury or

verification of disability caused by occupational disease, and there has been no pay rate change since the beginning of that work, the insurer must average irregular wages only for the weeks worked under the most recent wage earning agreement; and¶
(C) When there has been a pay rate change during the 52 weeks before the date of injury or verification of disability caused by occupational disease, and paragraph (b)(B) of this section does not apply, the insurer must calculate the worker's average weekly hours worked at each pay rate since a new wage earning agreement went into place, but not to exceed 52 weeks. The average weekly hours worked at each pay rate must then be multiplied by the pay rate(s) at the time of injury or verification of disability caused by occupational disease to determine the worker's average weekly wage for these wages. For the purpose of this rule, the "average weekly hours worked" includes all hours paid at an hourly rate which resulted in payment of irregular wages since the new wage earning agreement went into place, but not to exceed 52 weeks. This may include, but is not limited to, pay for regular hours, overtime, vacation, sick leave, paid time off, or bereavement leave. If there are irregular wages not paid at an hourly rate, the worker's average weekly wage under this paragraph must be added to the average of all of those other irregular wages paid at something other than an hourly rate.¶
(c) If, on the date of injury or verification of disability caused by occupational disease, the worker was employed by the employer at injury for less than four weeks, or the worker's most recent new wage earning agreement had been in place for less than four weeks, the insurer must base the rate of compensation on the intent of the worker's wage earning agreement in place at the time of injury or verification of disability caused by occupational disease, as confirmed by the employer and worker.¶
(5) Calculation of regular wages. If the worker receives regular wages, the insurer must calculate the worker's regular wages to determine the worker's average weekly wage:¶
(a) Daily wages must be multiplied by the number of days per week the worker was regularly employed;¶
(b) Monthly wages must be divided by 4.35; or¶
(c) Wages for other pay intervals must be calculated on an equivalent basis.¶
(6) Workers with no wages. If the worker is a volunteer, adult in custody, or other covered worker that receives no wages, the insurer must calculate the rate of compensation based on the assumed wage used to determine the employer's premium.¶
(7) Owners and corporate officers. If the worker is a sole proprietor, partner, officer of a corporation, or limited liability company member, the insurer must calculate the rate of compensation based on the assumed wage used to determine the employer's premium.¶
(8) Workers employed through a union hiring hall. For workers employed through a union hiring hall, the insurer must calculate the rate of compensation on the basis of a five-day work week at 40 hours a week, regardless of the number of days actually worked per week.¶
(a) The rate of compensation for workers employed through a union hiring hall with dates of injury on or after Jan~~uary.~~ 1, 2018, must be calculated under this section.¶
(b) The rate of compensation for workers employed through a union hiring hall with dates of injury from Jan~~uary.~~ 1, 2017, through Dec~~ember.~~ 31, 2017, must be calculated under this section, unless such calculation would result in a reduction of benefits.¶
(9) Wage disputes. If the worker disputes the wage used to calculate the rate of compensation, the insurer must attempt to resolve the dispute by reviewing its records and mathematical calculations, or by contacting the employer to confirm the correct wage. The insurer must then contact the worker with the results of its review and, if the wage was corrected, the new calculation. If the worker does not agree with the wage calculated by the insurer, the worker may request a hearing under OAR 436-060-0008.
Statutory/Other Authority: ORS 656.210(2), ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.704, ORS 656.210

AMEND: 436-060-0030

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0030 is amended to:

-Revise language and formatting of a modified job offer, effective Oct. 1, 2024.

-Specify that (1)(c) of this rule does not apply to a worker who is eligible for supplemental disability under OAR 436-060-0035.

CHANGES TO RULE:

436-060-0030
Payment of Temporary Partial Disability Compensation ¶

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

(c) The employer or insurer confirmed the offer of employment in writing to the worker stating:¶
(A) The beginning time, date, and place;¶
(B) The duration of the job, if known;¶
(C) The wages;¶
(D) An accurate description of the physical requirements of the job;¶
(E) The attending physician or authorized nurse practitioner has found the job to be within the worker's capabilities and the commute to be within the worker's physical capacity;¶
(F) The worker's right to refuse the offer of employment without termination of temporary total disability if any of the following conditions apply:¶
(i) The offer is at a site more than 50 miles from the location where the worker was injured or where the worker customarily reported for work, unless the work site is less than 50 miles from the worker's residence, or the job at the time of injury involved multiple or mobile work sites as established by the intent of the employer and worker at the time of hire or the employment pattern before the injury;¶
(ii) The offer is not with the employer at injury;¶
(iii) The offer is not at a work site of the employer at injury;¶
(iv) The offer is not consistent with existing written shift change policy or common practice of the employer at injury or aggravation; or¶
(v) The offer is not consistent with an existing shift change provision of an applicable union contract; and¶
(G) The following notice~~, i~~:¶
(i) In prominent or bold ~~face type~~text:¶
"If you refuse this offer of work for any of the reasons listed in this notice, you should write to the insurer or employer and tell them your reasons for refusing the job. If the insurer reduces or stops your temporary total disability and you disagree with that action, you have the right to request a hearing. To request a hearing you must send a letter objecting to the insurer's actions to the Worker's Compensation Board, 2601 25th Street SE, Suite 150, Salem, Oregon 97302-1282."¶
(ii) Effective no later than Oct. 1, 2024, the text in (G)(i) of this subsection must be replaced with the following language in bold and formatted as follows:¶
If you refuse this offer of work for any of the reasons listed in this notice, you should: ¶
¶
- Write to the insurer or employer, and¶
- Tell them your reasons for refusing the job. ¶
¶
If the insurer reduces or stops your temporary total disability, you may appeal by requesting a hearing. To request a hearing, send a letter objecting to the insurer's actions to: ¶
¶
Worker's Compensation Board ¶
2601 25th Street SE, Suite 150¶
Salem OR 97302-1280¶
(4) If the worker has been terminated from employment. The insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation as if the worker had begun the employment from the date the worker's attending physician or authorized nurse practitioner approves employment in a modified job that would have been offered to the worker if the worker had not been terminated from employment for violation of work rules or other disciplinary reasons, under the following conditions:¶
(a) The employer has a written policy of offering modified work to injured workers;¶
(b) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (1) of this rule;¶
(c) The attending physician or authorized nurse practitioner has been notified by the employer or insurer of the physical tasks to be performed by the injured worker; and¶
(d) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker's capabilities.¶
(5) If the worker is in violation of federal immigration law. The insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation as if the worker had begun the employment when the attending physician or authorized nurse practitioner approves employment in a modified job whether or not such a job is available if the worker is a person present in the United States in violation of federal immigration laws, under the following conditions:¶
(a) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (1) of this rule;¶

(b) The attending physician or authorized nurse practitioner has been notified by the employer or insurer of the physical tasks that would have been performed by the injured worker; and¶
(c) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker's capabilities.¶
(6) If the modified job no longer exists or offer is withdrawn. Temporary partial disability must be paid at the full temporary total disability rate as of the date a modified job no longer exists or the job offer is withdrawn by the employer.¶
(a) This section applies to situations including, but not limited to, termination of temporary employment, layoff, or plant closure.¶
(b) A worker who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim is subject to this section.¶
(c) For the purpose of this rule, when a worker who has been doing modified work quits the job, or the employer terminates the worker for violation of work rules or other disciplinary reasons, it is not a withdrawal of a job offer by the employer, but must be considered the same as the worker refusing wage earning employment under ORS 656.325(5)(a).¶
(d) This section does not apply to those situations described in sections (3), (4), and (5) of this rule.¶
(7) Termination of temporary partial disability. When the worker's disability is partial only and temporary in character, temporary partial disability compensation under ORS 656.212 must continue until:¶
(a) The attending physician or authorized nurse practitioner verifies the worker can no longer perform the modified job and is again temporarily totally disabled;¶
(b) The compensation is terminated by order of the director or by claim closure under ORS 656.268; or¶
(c) The compensation is lawfully suspended, withheld, or terminated for any other reason.¶
(8) Verbal release to work. If temporary disability benefits end because the insurer or employer negotiates a verbal release of the worker to return to any type of work with the worker's attending physician or authorized nurse practitioner, and the worker has not been informed of the release by the attending physician or authorized nurse practitioner or returned to work, the insurer must:¶
(a) Document the facts;¶
(b) Communicate the release to the worker by mail within seven days. The communication to the worker of the negotiated return-to-work release may be contained in an offer of modified employment; and¶
(c) Advise the worker of their reinstatement rights under ORS chapter 659A.¶
(9) Changes in the rate of compensation. When the insurer stops paying temporary total disability compensation and starts paying temporary partial disability compensation, or changes the compensation rate or the method of computation of benefits under this rule, the insurer must send written notice to the worker and worker's attorney, if any, under OAR 436-060-0015.
Statutory/Other Authority: ORS 656.212, 656.704, 656.726(4)
Statutes/Other Implemented: ORS 656.212, 656.704, 656.726(4), 656.268, 656.325(5)

AMEND: 436-060-0060

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0060 is amended to abbreviate dates cited in the rule.

CHANGES TO RULE:

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

(1) General. When an award for permanent partial disability is $6,000 or less, the insurer must pay the total amount of the award to the worker in a lump sum. When the award for permanent partial disability exceeds $6,000, the worker or worker's attorney may request a lump sum payment of all or part of the award. The insurer may only deny the request for lump sum payment if any of the following apply:¶
(a) The worker has not waived the right to appeal the adequacy of the award;¶
(b) The award has not become final by operation of law;¶
(c) The payment of compensation has been stayed pending a request for hearing or review under ORS 656.313; or¶
(d) The worker is enrolled and actively engaged in an authorized training plan under OAR 436-120 . For dates of injury before Jan~~uary.~~ 1, 2005, the insurer may not approve a request for lump sum payment of unscheduled permanent disability. For dates of injury on or after Jan~~uary.~~ 1, 2005, the insurer may not approve a request for lump sum payment of work disability when the worker:¶
(A) Has been found eligible for an authorized training plan under OAR 436-120 and will start the plan within 30 days of the date of the decision on the lump sum request;¶
(B) Is actively enrolled and engaged in an authorized training plan under OAR 436-120; or¶
(C) Has temporarily withdrawn from an authorized training plan under OAR 436-120.¶
(2) Application for approval. When an insurer receives a request for a lump sum payment from the worker or the worker's attorney, the insurer must send Form 1174, "Application for Approval of Lump-sum Payment of Award," to the requestor within 10 business days.¶
(3) Reopening of claims. For the purpose of this rule, each opening of the claim is considered a separate claim and any subsequent permanent partial disability award from a claim reopening is a new and separate award. Additional award of permanent partial disability obtained through the appeal process is considered part of the total cumulative award for the open period of that claim.¶
(4) Approved requests. If the insurer approves the worker's request for lump sum payment of a permanent partial disability award in excess of $6,000, the insurer must make the lump sum payment within 14 days of receipt of the signed application.¶
(5) Denied requests. If the insurer denies the worker's request for lump sum payment of a permanent partial disability award in excess of $6,000, the insurer must respond to the requestor within 14 days of receiving the request, explaining the reason for denying the lump sum request.¶
(6) Claim disposition agreements. A lump sum payment ordered in a litigation order or that is a part of a claim disposition agreement under ORS 656.236 does not require further approval by the insurer.¶
(7) Partial payments. When a lump sum payment for only part of an award is approved by the insurer, it must be paid in addition to the regularly scheduled monthly payment. The remaining balance must be paid under ORS 656.216. Denial or partial approval of a request does not preclude another request by the worker for a lump sum payment of all or part of any remainder of the award, provided additional information is submitted.
Statutory/Other Authority: ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.704, ORS 656.726(4), ORS 656.230

AMEND: 436-060-0095

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0095 is amended to revise language and formatting of a notice of an independent medical examination, and of the insurer's request to suspend compensation, effective October 1, 2024.

CHANGES TO RULE:

436-060-0095
Medical Examinations; Suspension of Compensation; and Independent Medical Examination Notice ¶

(1) General. A worker must submit to independent medical examinations reasonably requested by the insurer or the director.¶
(a) The conditions of the examination must be consistent with conditions described in OAR 436-010-0265.¶
(b) If the worker refuses or fails to submit to, or otherwise obstructs, an independent medical examination reasonably requested by the insurer or the director under ORS 656.325(1), the director may suspend compensation by order:¶
(A) The worker must have the opportunity to dispute the suspension of compensation before the director will issue the order; and¶
(B) Compensation will be suspended until the examination has been completed. The worker is not entitled to compensation during or for the period of suspension.¶
(c) Any action of a worker's observer allowed under OAR 436-010-0265(6) that obstructs the examination may be considered an obstruction of the examination by the worker for the purpose of this rule.¶
(d) The director may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination.¶
(e) The director may impose a monetary penalty against the worker under OAR 436-010-0265.¶
(2) Number of examinations. The insurer may request no more than three separate independent medical examinations for each opening of a claim, except as provided under OAR 436-010. Examinations after the worker's claim is closed are subject to limitations in ORS 656.268(8).¶
(3) Scheduling and notice to worker. The insurer may contract with a third party to schedule independent medical examinations. When an examination is scheduled by the insurer, or by a third party at the request of the insurer:¶
(a) The worker and the worker's attorney, if any, must be simultaneously notified in writing of the scheduled medical examination;¶
(b) The notice must be mailed at least 10 days before the examination;¶
(c) If the third party notifies the worker of a scheduled examination on behalf of the insurer, the appointment notice must be sent on the insurer's stationery; ~~and~~¶
(d) The insurer must include with each appointment notice it sends to the worker:¶
(A) Form 3921, "Request for Reimbursement of Expenses," or a similar form for requesting reimbursement; and¶
(B) Form 3923, "Important Information about Independent Medical Exams"; and¶
(e) The notice sent for each appointment, including those which have been rescheduled, must contain the following:¶
(A) The name of the examiner or facility;¶
(B) A statement of the specific purpose for the examination and, identification of the medical specialties of the examiners;¶
(C) The date, time, and place of the examination;¶
(D) The first and last name of the attending physician or authorized nurse practitioner and verification that the attending physician or authorized nurse practitioner was informed of the examination by, at least, a copy of the appointment notice, or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;¶
(E) If applicable, confirmation that the director has approved the examination;¶
(F) A statement that the reasonable cost of public transportation or use of a private vehicle will be reimbursed and that, when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance;¶
(G) A statement that an amount will be paid equivalent to net lost wages for the period during which it is necessary to be absent from work to attend the medical examination if benefits are not received under ORS 656.210(4) during the absence;¶
(H) A statement that the worker has the right to have an observer present at the examination, but the observer

may not be compensated in any way for attending the exam; however, for a psychological examination, the notice must explain that an observer is allowed to be present only if the examination provider approves the presence of an observer; and¶
(I) The following notice~~i~~:¶
(i) In prominent or bold ~~face type~~text:¶
"You must attend this examination. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the examination. If you fail to attend and do not have a good reason for not attending, or you fail to cooperate with the examination, your workers' compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.325 and OAR 436-060. You may be charged a $100 penalty if you fail to attend without a good reason or if you fail to notify the insurer before the examination. The penalty is taken out of future benefits.¶
If you object to the location of this appointment you must contact the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 or the Ombuds Office for Oregon Workers at 1-800-927-1271."¶
~~(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, "Importan~~ii) Effective no later than Oct. 1, 2024, the text in (I)(i) of this subsection must be replaced with the following language in bold and formatted as follows:¶
You must attend this examination. If there is any reason you cannot attend, you must tell us as soon as possible before the date of the examination. ¶
¶
If you disagree with the location of this appointment, you must contact the Workers' Compensation Division at 800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice. ¶
¶
Your workers' compensation benefits may be suspended under Oregon laws and rules* if you: ¶
¶
- Do not attend the examination, ¶
- Do not have a good reason for not attending the examination, or ¶
- Do not cooperate with the examination. ¶
¶
You may be charged a $100 penalty if you do not attend the examination without good reason or if you do not notify the insurer before the examination. The penalty is taken out of future benefits. ¶
¶
If you have any questions you may call: ¶
- [Insurer] at [In~~formation about Independent Medical Exams."~~surer phone number] ¶
- Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585 ¶
- Ombuds Office for Oregon Workers at 800-927-1271 (toll-free)¶
¶
*Oregon Revised Statute 656.325 and Oregon Administrative Rules, Chapter 436, division 60¶
(4) Reimbursement of costs. When a worker attends an independent medical examination the insurer must reimburse the worker for reasonable costs in accordance with OAR 436-009-0025 regardless of claim acceptance, deferral, or denial.¶
(5) Forwarding of reports from provider. Following completion of the examination, the insurer must forward a copy of the examiner's signed report to the attending physician or authorized nurse practitioner within three business days of the insurer's receipt of the report.¶
(6) Requests to authorize suspension. The director will consider requests to authorize suspension of benefits on accepted claims, deferred claims, and denied claims in which the worker has appealed the insurer's denial. The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service in the same manner as a summons. The request must include the following information:¶
(a) That the insurer requests suspension of compensation under ORS 656.325 and OAR 436-060-0095;¶
(b) The claim status and any accepted or newly claimed conditions;¶
(c) What specific actions of the worker prompted the request;¶
(d) The dates of any prior independent medical examinations the worker has attended in the current open period of the claim and the names of the examining physicians or facilities, or a statement that there have been no prior examinations, whichever is appropriate;¶
(e) A copy of any approvals given by the director for more than three independent medical examinations, or a statement that no approval was necessary, whichever is appropriate;¶

(f) Any reasons given by the worker for failing to comply, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;¶
(g) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the exam received by the insurer from the worker or the worker's attorney will be sufficient documentation with which to request suspension;¶
(h) A copy of the notice required in section (3) and a copy of any written verification received under subsection (6)(g) of this rule;¶
(i) Any other information that supports the request; and¶
(j) The following notice~~i~~:¶
(A) In prominent or bold ~~face type~~text:¶
"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. If the division grants this request, you may lose all or part of your benefits. If your claim has not yet been accepted, your future benefits, if any, will be jeopardized."¶
(B) Effective no later than Oct. 1, 2024, the text in (j)(A) of this section must be replaced with the following language in bold and formatted as follows:¶
Notice to worker:¶
¶
If the Workers' Compensation Division grants this request, you may lose all or part of current or future benefits. ¶
¶
If you think this request to suspend your compensation is wrong, write to the Workers' Compensation Division immediately. ¶
¶
- Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. ¶
¶
- Address your letter to: ¶
¶
Workers' Compensation Division ¶
350 Winter Street NE ¶
PO Box 14480 ¶
Salem OR 97309-0405 ¶
¶
If you have any questions, you may call the Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585.¶
(7) Effective date of suspension. If the director authorizes the suspension of compensation, the suspension will be effective from the date the worker fails to attend an examination or such other date the director deems appropriate until the date the worker undergoes an examination scheduled by the insurer or director. Any delay in requesting consent for suspension may result in authorization being denied or the date of authorization being modified.¶
(8) Reinstatement of benefits. The insurer must assist the worker in meeting requirements necessary for the resumption of compensation payments. When the worker has undergone the independent medical examination, the insurer must verify the worker's participation and reinstate compensation effective the date of the worker's compliance.¶
(9) Claim closure. If the worker makes no effort to reinstate compensation in an accepted claim within 60 days of the mailing date of the consent to suspend order, the insurer must close the claim under OAR 436-030-0034.¶
(10) Denial of suspension. If the director denies the insurer's request for suspension of compensation, the insurer will be notified of the reason for denial. Failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.¶
(11) Other actions by the director. The director may also take the following actions concerning the suspension of compensation:¶
(a) Modify or set aside the order of consent before or after a request for hearing is filed;¶
(b) Order payment of compensation previously suspended when the director finds the suspension to have been made in error; and¶
(c) Reevaluate the necessity of continuing a suspension.¶
(12) Final orders. An order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the board.
Statutory/Other Authority: ORS 656.325, ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.325, ORS 656.704, ORS 656.726(4)

AMEND: 436-060-0105

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0105 is amended to revise language and formatting of a notice to the worker to cease insanitary or injurious practices, of the insurer's request to suspend compensation, and of the insurer's request to reduce compensation, effective Oct. 1, 2024.

CHANGES TO RULE:

436-060-0105
Suspension of Compensation for Insanitary or Injurious Practices, Refusal of Treatment or Failure to Participate in Rehabilitation; Reduction of Benefits ¶

(1) General. The director may suspend compensation by order when the worker commits insanitary or injurious acts that imperil or delay recovery; refuses to submit to medical or surgical treatment reasonably required to promote recovery; or fails or refuses to participate in a physical rehabilitation program.¶
(a) The worker must have the opportunity to dispute the suspension of compensation before the director will issue an order.¶
(b) The worker is not entitled to compensation during or for the period of suspension.¶
(2) Notice to worker. The insurer must demand in writing the worker either immediately cease all actions which imperil or delay recovery or immediately begin to change the inappropriate behavior, and participate in activities needed to help the worker recover from the injury. Each time the insurer sends such a notice to the worker, the written demand must contain the following information, and a copy must be sent simultaneously to the worker's attorney and attending physician:¶
(a) A description of the unacceptable actions;¶
(b) Why such conduct is inappropriate, including the fact that the conduct is harmful or delays the worker's recovery, as appropriate;¶
(c) The date by which the inappropriate actions must stop, or the date by which compliance is expected, including what the worker must specifically do to comply; and;¶
(d) The following notice of the consequences should the worker fail to correct the problem~~,~~ i:¶
(A) In prominent or bold ~~face type~~text:¶
"If you continue to do insanitary or injurious acts beyond the date in this letter, or fail to consent to the medical or surgical treatment which is needed to help you recover from your injury, or fail to participate in physical rehabilitation needed to help you recover as much as possible from your injury, then we will request the suspension of your workers' compensation benefits. In addition, you may also have any permanent disability award reduced in accordance with ORS 656.325 and OAR 436-060."¶
(B) Effective no later than Oct. 1, 2024, the text in (d)(A) of this section must be replaced with the following language in bold and formatted as follows:¶
If you continue this inappropriate conduct after the above date: ¶
¶
- We will ask that your workers' compensation benefits be suspended, and ¶
- Your permanent disability award, if any, may be reduced under ORS 656.325 and OAR 436-060.¶
(3) Failure or refusal to accept medical treatment. For the purposes of this rule, failure or refusal to accept medical treatment means the worker fails or refuses to remain under a physician's or authorized nurse practitioner's care or abide by a treatment regimen. A treatment regimen includes, but is not limited to a prescribed diet, exercise program, medication or other activity prescribed by the physician or authorized nurse practitioner that is designed to help the worker reach maximum recovery and become medically stationary.¶
(4) Request for suspension of benefits. The insurer must verify whether the worker complied with the request for cooperation on the date specified in subsection (2)(c) of this rule. If the worker initially agrees to comply, or complies and then refuses or fails to continue doing so, the insurer is not required to send further notice before requesting suspension of compensation.¶
(a) The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney, if any, by registered or certified mail or by personal service as for a summons.¶
(b) The request must include the following information:¶
(A) That the request for suspension is made in accordance with ORS 656.325 and OAR 436-060-0105;¶
(B) A description of the actions of the worker that prompted the request, including whether such actions continue;¶
(C) Any reasons offered by the worker to explain the behavior, or a statement that the worker has not provided

any reasons, whichever is appropriate;¶
(D) How, when, and with whom the worker's failure to comply or refusal to comply was verified;¶
(E) A copy of the notice required in section (2) of this rule;¶
(F) Any other relevant information including, but not limited to; chart notes, surgical or physical therapy recommendations/prescriptions, and all recommendations from the attending physician or authorized nurse practitioner; and¶
(G) The following notice~~i~~:¶
(i) In prominent or bold ~~face type~~text:¶
"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. If the division authorizes suspension of your compensation and you do not correct your unacceptable actions or show us a good reason why they should be considered acceptable, we will close your claim."¶
(ii) Effective no later than Oct. 1, 2024, the text in (G)(i) of this subsection must be replaced with the following language in bold and formatted as follows:¶
Notice to worker: ¶
¶
If the Workers' Compensation Division decides to suspend your benefits and you do not correct your unacceptable actions, or show us a good reason why they are acceptable, we will close your claim. ¶
¶
If you think this request to suspend your benefits is wrong, write to the Workers' Compensation Division immediately. ¶
¶
- Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. ¶
¶
- Address your letter to: ¶
¶
Workers' Compensation Division ¶
350 Winter Street NE ¶
PO Box 14480 ¶
Salem OR 97309-0405 ¶
¶
If you have any questions, you may call the Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585.¶
(c) Any delay in obtaining confirmation or in requesting the suspension of compensation may result in authorization being denied or the date of authorization being modified by the date of actual confirmation or the date the request is received by the division.¶
(d) If the director approves authorization of suspension of compensation:¶
(A) An order will be issued suspending compensation from a date established under subsection (2)(c) of this rule until the worker complies with the insurer's request for cooperation. Where the worker is suspended for a pattern of noncooperation, the director may require the worker to demonstrate cooperation before reinstating compensation;¶
(B) The insurer must make all reasonable efforts to assist the worker to reinstate benefits when the worker demonstrates the willingness to make such efforts;¶
(C) The insurer must monitor the claim to determine if and when the worker complies with the insurer's requests;¶
(i) When cooperation resumes, payment of compensation must resume effective the date cooperation was resumed;¶
(ii) If the worker makes no effort to reinstate benefits within 60 days of the mailing date of the suspension order, the insurer must close the claim under OAR 436-030-0034;¶
(D) The director may modify or set aside the suspension order before or after filing of a request for hearing;¶
(E) The director may order payment of compensation previously suspended where the director finds the suspension to have been made in error;¶
(F) The director may re-evaluate the necessity of continuing a suspension; and¶
(G) The order will become final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the board.¶
(e) If the director denies the insurer's request for suspension of compensation, the insurer will be notified of the reason for denial. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.¶

(5) Requests to reduce benefits. The director may reduce any benefits awarded the worker under ORS 656.268 when the worker has unreasonably failed to follow medical advice, or failed to participate in a physical rehabilitation program or vocational assistance program prescribed for the worker under ORS chapter 656 and OAR chapter 436. Such benefits must be reduced by the amount of the increased disability reasonably attributable to the worker's failure to cooperate.¶
(a) When an insurer submits a request to reduce benefits under this section, the insurer must:¶
(A) Specify the basis for the request;¶
(B) Include all supporting documentation;¶
(C) Send a copy of the request, including the supporting documentation, to the worker and the worker's attorney, if any, by certified mail; and¶
(D) Include the following notice~~:~~:¶
(i) In prominent or bold ~~face type~~text:¶
"Notice to worker: If you think this request to reduce your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the mailing date of this request. If the division grants this request, you may lose all or part of your benefits."¶
(ii) Effective no later than Oct. 1, 2024, the text in (D)(i) of this subsection must be replaced with the following language in bold and formatted as follows:¶
Notice to worker: ¶
¶
If the Workers' Compensation Division grants this request, you may lose all or part of your benefits. ¶
¶
If you think this request to reduce your benefits is wrong, write to the Workers' Compensation Division immediately. ¶
¶
- Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. ¶
¶
- Address your letter to: ¶
¶
Workers' Compensation Division ¶
350 Winter Street NE ¶
PO Box 14480 ¶
Salem OR 97309-0405¶
¶
If you have any questions, you may call the Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585.¶
(b) The director will make a decision on a request to reduce benefits and notify the parties of the decision. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the request to reduce benefits.
Statutory/Other Authority: ORS 656.325, ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.325, ORS 656.704, ORS 656.726(4)

AMEND: 436-060-0135

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0135 is amended to:

-Revise language and formatting of a notice of a scheduled interview or deposition, or other investigation requirements, effective Oct. 1, 2024.

-Clarify that the insurer must include available written documentation of the worker's request to file a claim, including forms 801 and 827 when the insurer requests a suspension of benefits.

-Revise the worker's options for contacting the division when the director notifies the parties that the worker's benefits may be suspended.

CHANGES TO RULE:

436-060-0135
Injured Worker, Workers Attorney Responsible to Assist in Investigation; Suspension of Compensation and Notice to Worker ¶

(1) Worker's responsibility to assist in investigation. A worker must submit to and fully cooperate with in person or telephone interviews and other formal or informal information gathering techniques reasonably requested by the insurer. Interviews may be recorded on audio or video by one or more of the parties if prior written notice is given of the intent to record an interview.¶
(2) Request to suspend compensation. The insurer may request for the director to suspend compensation by order when the worker refuses or fails to cooperate in an investigation of an initial claim for compensation, a claim for a new medical condition, a claim for an omitted medical condition, or an aggravation claim as required by ORS 656.262(14), under the following conditions:¶
(a) The insurer must notify the worker in writing that an interview or deposition has been scheduled, or of other investigation requirements:¶
(A) The notice must be sent to the worker and copied to the worker's attorney, if any, and must contain the following:¶
(i) The date, time, and place of the interview or deposition, if scheduled;¶
(ii) Any other reasonable investigation requirements;¶
(iii) That the interview, deposition, or any other investigation requirements are related to the worker's compensation claim; and¶
(iv) The following statement~~i~~:¶
(I) In prominent or bold ~~face type~~text:¶
"The workers' compensation law requires injured workers to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers are required to submit to and fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. If you do not reasonably cooperate with the investigation of this claim, payment of your compensation benefits may be suspended and your claim may be denied in accordance with ORS 656.262 and OAR 436-060."¶
(II) Effective no later than Oct. 1, 2024, the text in (iv)(I) of this paragraph must be replaced with the following language in bold and formatted as follows:¶
The law requires you to cooperate and assist in the investigation of your workers' compensation claim. This means you must take part and fully cooperate with: ¶
¶
- Personal and telephone interviews, and ¶
- Other formal or informal information gathering techniques. ¶
¶
If you do not reasonably cooperate: ¶
¶
- Your workers' compensation benefits may be suspended, and ¶
- Your claim may be denied under ORS 656.262 and OAR 436-060.¶
(B) If the insurer contracts with a third party to investigate the claim, the notice must be on the insurer's stationery and must meet the requirements of this section; and¶
(C) The worker must be given 14 days to cooperate with the notice.¶
(b) The director will consider requests to authorize suspension of benefits only after the worker has been given at least 14 days to cooperate with the notice under subsection (a) of this rule; and under the following conditions:¶
(A) The director will only consider requests in claims on which no acceptance or denial has been issued;¶

(B) The worker must have the opportunity to submit information disputing the insurer's request for suspension of compensation before the director will issue an order;¶
(C) The director may determine whether special circumstances exist that would not warrant suspension of compensation for failure to cooperate with an investigation;¶
(D) The insurer must make the request to suspend benefits to the director in writing, and must send a copy of the request, including all attachments, simultaneously to the worker and the worker's attorney, if any by registered or certified mail or by personal service;¶
(E) The insurer's request must include the following information sufficient to show the worker's failure to cooperate:¶
(i) That the insurer requests suspension of benefits under ORS 656.262(15) and this rule;¶
(ii) Documentation of the specific actions of the worker or worker's attorney that prompted the request;¶
(iii) Any reasons given by the worker for failure to comply, or a statement that the worker has not given any reasons;¶
(iv) A copy of the notice required in (2)(a) of this rule; ¶
(v) All available written documentation of the worker's notice to file a claim, including, but not limited to, a copy of Form 801 and Form 827; and¶
(vi) All other pertinent information, including, but not limited to, a copy of the claim for a new or omitted condition when that is what the insurer is investigating;.¶
(c) After receiving the insurer's request to suspend benefits, the director will notify all parties that:¶
(A) The worker's benefits will be suspended in five business days unless:¶
(i) The worker or the worker's attorney contacts the division ~~by telephone or mails a letter documenting that the~~as specified in the director's notice and explains how the worker's failure to cooperate was reasonable; or¶
(ii) The insurer notifies the division that the worker is now cooperating;¶
(B) The insurer's obligation to accept or deny the claim within 60 days is suspended unless the insurer's request is filed with the division after the 60 days to accept or deny the claim has expired;¶
(d) If the worker cooperates within five business days of the director's notice under subsection (c), the insurer must notify the director immediately to withdraw the suspension request. Upon receiving the insurer's notification:¶
(A) The director will notify all the parties of the withdrawal; and¶
(B) The director may issue an order identifying the dates during which the insurer's obligation to accept or deny the claim was suspended;¶
(e) If the worker contacts the division and documents the failure to cooperate was reasonable within five business days of the director's notice under subsection (c), the director will not suspend payment of compensation. However, an order may be issued identifying the dates during which the insurer's obligation to accept or deny the claim was suspended; and¶
(f) If the worker has not cooperated with the investigation, or has not documented that the failure to cooperate was reasonable within five business days of the director's notice under subsection (c), the director will issue an order suspending all or part of the payment of compensation to the worker:¶
(A) The suspension of compensation will be effective from the fifth business day after the date of the director's notice under subsection (c), and will remain in effect until the worker reasonably cooperates with the investigation;¶
(B) If the worker reasonably cooperates with the investigation, the insurer must reinstate the worker's benefits immediately; or¶
(C) If the worker makes no effort to cooperate within 30 days of the date of the notice, the insurer may deny the claim under ORS 656.262(15) and OAR 436-060-0140(8).¶
(3) Request for penalty against worker's attorney. An insurer that believes that a worker's attorney's unwillingness or unavailability to participate in an interview is unreasonable may notify the director in writing and the director will consider assessment of a civil penalty against the attorney of not more than $1,000.¶
(a) The worker's attorney must have the opportunity to dispute the allegation before a penalty is assessed.¶
(b) A copy of the notice must be sent simultaneously to the worker and the worker's attorney. Notice to the division by the insurer must contain the following information:¶
(A) What specific actions of the attorney prompted the request;¶
(B) Any reasons given by the attorney for failing to participate in the interview; and¶
(C) A copy of the request for interview sent to the attorney.¶
(4) Failure to comply with this rule. Failure to comply with the requirements of this rule will be grounds for denial of the insurer's request. Any delay in requesting suspension under section (2) of this rule may result in authorization being denied.
Statutory/Other Authority: ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.704, ORS 656.726(4), ORS 656.262

AMEND: 436-060-0137

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0137 is amended to revise language and formatting of a notice of a required vocational evaluation and of a request for suspension, effective Oct. 1, 2024.

CHANGES TO RULE:

436-060-0137
Vocational Evaluations for Permanent Total Disability Benefits; and Suspension of Compensation ¶

(1) Requests for vocational evaluations. A worker receiving permanent total disability benefits must attend a vocational evaluation reasonably requested by the insurer or the director.¶
(2) Allowed number of vocational evaluations. The insurer may request no more than three separate vocational evaluations without authorization from the director. Insurers that fail to obtain authorization from the director for additional vocational evaluations may be assessed a civil penalty.¶
(a) To request authorization the insurer must:¶
(A) Submit a written request for authorization that includes:¶
(i) The reasons for an additional vocational evaluation;¶
(ii) The conditions to be evaluated;¶
(iii) The dates, times, places, and purposes of previous evaluations;¶
(iv) Copies of previous vocational evaluation notification letters to the worker; and¶
(v) Any other information requested by the director;¶
(B) Provide a copy of the request to the worker and the worker's attorney, if any.¶
(b) The director will review the request and determine if additional information is needed.¶
(A) Upon receipt of a request for additional information from the director, the parties will have 14 days to respond.¶
(B) If the parties do not provide the requested information, the director will approve or disapprove the request for authorization based on available information.¶
(c) The director's decision approving or denying more than three vocational evaluations may be appealed to the board within 60 days of the order.¶
(d) For purposes of determining the number of insurer required vocational evaluations, any evaluations scheduled but not completed are not counted as a statutory vocational evaluation.¶
(3) Notice to worker. The insurer must notify the worker of the evaluation at least 10 days before the date of evaluation.¶
(a) The notice sent for each evaluation, including evaluations that have been rescheduled, must contain the following:¶
(A) The name of the vocational assistance provider or facility;¶
(B) A statement of the specific purpose for the evaluation;¶
(C) The date, time and place of the evaluation;¶
(D) The first and last name of the attending physician or authorized nurse practitioner or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;¶
(E) If applicable, confirmation that the director has approved the evaluation;¶
(F) Notice to the worker that the reasonable cost of public transportation or use of a private vehicle will be reimbursed; when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed; a request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request; should an advance of costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance; and¶
(G) The following notice~~:~~;¶
(i) In prominent or bold ~~face type~~text:¶
"You must attend this vocational evaluation. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the evaluation. If you do not attend or do not cooperate, or do not have a good reason for not attending, your compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.206 and OAR 436-060. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or the Ombuds Office for Oregon Workers at 1-800-927-1271."¶
(ii) Effective no later than Oct. 1, 2024, the text in (G)(i) of this subsection must be replaced with the following language in bold and formatted as follows:¶
You must attend this evaluation. ¶

¶
If there is any reason you cannot attend, you must tell us as soon as possible before the date of the evaluation. ¶
¶
Your workers' compensation benefits may be suspended under Oregon laws and rules* if you: ¶
¶
- Do not attend the evaluation, ¶
- Do not cooperate with the evaluation, or ¶
- Do not have good reason for not attending. ¶
¶
If you have any questions you may call: ¶
- [Insurer] at [Insurer phone number] ¶
- Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585 ¶
- Ombuds Office for Oregon Workers at 800-927-1271 (toll-free). ¶
¶
*Oregon Revised Statute 656.206 and Oregon Administrative Rules Chapter 436, division 60¶
(b) The insurer may contract with a third party to schedule vocational evaluations. If the third party notifies the worker of a scheduled evaluation on behalf of the insurer, the third party must send the notice on the insurer's stationery and the notice must meet the requirements of this section.¶
(4) Reimbursements of costs. The insurer must pay the costs of the vocational evaluation and related services necessary to allow the worker to attend the evaluation, including a reasonable cost of public transportation or use of a private vehicle, and when necessary, a reasonable cost of child care, meals, lodging and other related services. Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, comply with this rule.¶
(5) Suspension of compensation. When the worker refuses or fails to attend, or otherwise obstructs, a vocational evaluation reasonably requested by the insurer or the director, the director may suspend the worker's compensation by order, under the following conditions:¶
(a) The insurer must send the request for suspension to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service;¶
(b) The request must include the following information:¶
(A) That the insurer requests suspension of benefits under ORS 656.206 and OAR 436-060-0137;¶
(B) What specific actions of the worker prompted the request;¶
(C) The dates of any prior vocational evaluations the worker has attended and the names of the vocational assistance provider or facilities, or a statement that there have been no prior evaluations, whichever is appropriate;¶
(D) A copy of any approvals given by the director for more than three vocational evaluations, or a statement that no approval was necessary, whichever is appropriate;¶
(E) Any reasons given by the worker for failing to attend, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;¶
(F) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the vocational evaluation received by the insurer from the worker or the worker's attorney will be sufficient documentation with which to request suspension;¶
(G) A copy of the letter required in section (3) of this rule and a copy of any written verification received under paragraph (F) of this subsection;¶
(H) Any other information that supports the request; and¶
(I) The following notice~~i~~:¶
(i) In prominent or bold ~~face type~~text:¶
"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. If the division grants this request, you may lose all or part of your benefits."¶
(ii) Effective no later than Oct. 1, 2024, the text in (I)(i) of this subsection must be replaced with the following language in bold and formatted as follows:¶
Notice to worker: ¶
¶
If the Workers' Compensation Division grants this request, you may lose all or part of your benefits. ¶
¶
If you think this request to suspend your compensation is wrong, write to the Workers' Compensation Division immediately. ¶

¶
- Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. ¶
¶
- Address your letter to: ¶
¶
Workers' Compensation Division ¶
350 Winter Street NE ¶
PO Box 14480 ¶
Salem OR 97309-0405 ¶
¶
If you have any questions, you may call: ¶
- [Insurer] at [Insurer phone number]¶
- Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585 ¶
- Ombuds Office for Oregon Workers at 800-927-1271 (toll-free)¶
(c) If the director suspends compensation:¶
(A) The suspension will be effective from the date the worker fails to attend a vocational evaluation or such other date the director determines is appropriate until the date the worker attends the evaluation;¶
(B) The worker is not entitled to compensation during or for the period of suspension;¶
(C) The insurer must assist the worker to meet requirements necessary for the resumption of compensation payments. When the worker has attended the vocational evaluation, the insurer must verify the worker's participation and resume compensation effective the date of the worker's compliance;¶
(D) The director may modify or set aside the suspension order before or after filing of a request for hearing;¶
(E) The director may order payment of compensation previously suspended where the director finds the suspension to have been made in error; and¶
(F) The director may re-evaluate the necessity of continuing a suspension;¶
(d) If the insurer fails to comply with this rule, the director may deny the request for suspension. Any delay in requesting suspension may result in suspension being denied or the date of suspension being modified; and¶
(e) A suspension order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the board.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.206

AMEND: 436-060-0140

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0140 is amended to abbreviate dates cited in the rule

CHANGES TO RULE:

436-060-0140
Acceptance or Denial of a Claim ¶

(1) Claim investigations. The insurer is required to conduct a "reasonable" investigation based on all available information in determining whether to deny a claim.¶
(a) A reasonable investigation is whatever steps a reasonably prudent person with knowledge of the legal standards for determining compensability would take in a good faith effort to ascertain the facts underlying a claim, giving due consideration to the cost of the investigation and the likely value of the claim.¶
(b) In determining whether an investigation is reasonable, the director will only look at information contained in the insurer's claim record at the time of denial. The insurer may not rely on any fact not documented in the claim record at the time of denial to establish that an investigation was reasonable.¶
(2) Notice to worker. The insurer must give the worker written notice of acceptance or denial of a claim within the following time frames:¶
(a) For claims with a date of injury before Jan~~uary.~~ 1, 2002, within 90 days of:¶
(A) The employer's notice or knowledge of an initial claim;¶
(B) The insurer's receipt of a Form 827 signed by the worker or the worker's attorney, and the worker's attending physician indicating an aggravation claim; or¶
(C) Written notice of a new medical condition claim;¶
(b) For claims with a date of injury on or after Jan~~uary.~~ 1, 2002, within 60 days after:¶
(A) The employer's notice or knowledge of an initial claim;¶
(B) The insurer's receipt of a Form 827 signed by the worker or the worker's attorney and the worker's attending physician indicating an aggravation claim; or¶
(C) Written notice of a new medical or omitted condition claim; or¶
(c) For claims with any date of injury, if the worker challenges the location of an independent medical examination under OAR 436-010-0265 and the challenge is upheld, within 90 days after the employer's notice or knowledge of the claim.¶
(3) Penalty for untimely acceptance and denials. The director may assess a penalty under OAR 436-060-0200 against any insurer delinquent in accepting or denying a claim beyond the time frame required under section (2) of this rule.¶
(4) Notice of acceptance. A notice of acceptance must comply with ORS 656.262(6)(b) and OAR chapter 438. It must include a current mailing date, be addressed to the worker, be copied to the worker's attorney, if any, and the worker's attending physician, and describe to the worker:¶
(a) What conditions are compensable;¶
(b) Whether the claim is disabling or nondisabling;¶
(c) The Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that the injury is nondisabling by requesting the insurer review the status;¶
(d) The employment reinstatement rights and responsibilities under ORS chapter 659A;¶
(e) Assistance available to employers from the Re-employment Assistance Program under ORS 656.622;¶
(f) That claim related expenses paid by the worker must be reimbursed by the insurer when requested in writing and accompanied by sales slips, receipts, or other reasonable written support, for meals, lodging, transportation, prescriptions and other related expenses. The worker must be advised of the two year time limitation to request reimbursement as provided in OAR 436-009-0025 and that reimbursement of expenses may be subject to a maximum established rate;¶
(g) That if the worker believes a condition has been incorrectly omitted from the notice of acceptance, or the notice is otherwise deficient, the worker must first communicate the objection to the insurer in writing specifying either that the worker believes the condition has been incorrectly omitted or why the worker feels the notice is otherwise deficient; and¶
(h) That if the worker wants the insurer to accept a claim for a new medical condition, the worker must put the request in writing, clearly identify the condition as a new medical condition, and request formal written acceptance of the condition.¶
(5) Notice of acceptance, fatal claims. In the case of a fatal claim, the notice must be addressed "to the estate of" the worker and the requirements of subsection (4)(a) through (h) of this rule must not be included.¶

(6) Initial, modified, and updated notices of acceptance.¶
(a) The first acceptance issued on the claim must contain the title "Initial Notice of Acceptance" near the top of the notice. Any notice of acceptance must contain all accepted conditions at the time of the notice.¶
(b) An insurer must issue a "Modified Notice of Acceptance" (MNOA) when the insurer:¶
(A) Accepts a new or omitted condition on a nondisabling claim, while a disabling claim is open or after claim closure;¶
(B) Accepts an aggravation claim;¶
(C) Changes the disabling status of the claim; or¶
(D) Amends a notice of acceptance, including correcting a clerical error, except for an error or omission on an "Updated Notice of Acceptance at Closure."¶
(c) When an insurer closes a claim, it must issue an "Updated Notice of Acceptance at Closure" under OAR 436-030-0015.¶
(7) Acceptance of new or omitted conditions. When an insurer accepts a new or omitted condition on a closed claim, the insurer must reopen the claim and process it to closure under ORS 656.262 and 656.267. When a claim is reopened, the notice of acceptance must specify the conditions for which the claim is being reopened.¶
(8) Notice of denial to worker. A notice of denial must comply with OAR chapter 438 and the following:¶
(a) The notice must specify the factual and legal reasons for the denial, including a specific statement indicating if the denial was based in whole or part on an independent medical examination under ORS 656.325;¶
(b) If the denial was based in whole or part on an independent medical examination under ORS 656.325:¶
(A) The notice must include one of the following statements, as appropriate:¶
(i) "Your attending physician agreed with the independent medical examination report";¶
(ii) "Your attending physician did not agree with the independent medical examination report"; or¶
(iii) "Your attending physician has not commented on the independent medical examination report"; and¶
(B) If subparagraph (8)(b)(A)(ii) or (iii) of this rule apply, the notice must include the division's website address and toll-free phone number for the worker's use in obtaining a brochure about the worker requested medical examination.¶
(c) The notice must inform the worker of the Expedited Claim Service and of the worker's right to a hearing under ORS 656.283; and¶
(d) If the denial is under ORS 656.262(15), the notice must inform the worker that a hearing may occur sooner if the worker requests an expedited hearing under ORS 656.291.¶
(9) Notice of denial to provider of medical services and health insurance. The insurer must send notice of the denial to each medical service provider and provider of health insurance as defined under ORS 731.162 when compensability of any portion of a claim for medical services is denied. The notice must be sent:¶
(a) At the same time the denial is sent to the worker;¶
(b) Within 14 days of receipt of any billings from medical providers not previously notified of the denial. The notice must advise the medical provider of the status of the denial; or¶
(c) Within 60 days of the date when compensability of the claim has been finally determined or when disposition of the claim has been made. The notification must include the results of the proceedings under ORS 656.236 or 656.289(4) and the amount of any settlement.¶
(10) Payment of compensation. The insurer must pay compensation due under ORS 656.262 and 656.273 until the claim is denied, except where there is an issue concerning the timely filing of a notice of accident as provided in ORS 656.265(4). The employer may elect to pay compensation under this section in lieu of the insurer doing so. The insurer must report to the division payments of compensation made by the employer as if the insurer had made the payment.¶
(11) Medical benefits and funeral expenses. Compensation payable to a worker or the worker's beneficiaries while a claim is pending acceptance or denial does not include:¶
(a) The costs of medical benefits; or¶
(b) The cost of final disposition of the body or funeral expenses.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.726(4), 656.262, 656.325

AMEND: 436-060-0150

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0150 is amended to specify temporary disability may be paid in accordance with the employer's payroll schedule and pay period, and when the insurer's claim file must include written documentation of the payroll schedule and pay period.

CHANGES TO RULE:

436-060-0150
Timely Payment of Compensation ¶

(1) General. Benefits are considered paid when addressed to the last known address of the worker or beneficiary and deposited in the U.S. Mail, or when funds are transferred to a financial institution for deposit in the worker's or beneficiary's account by approved electronic equivalent.¶
(2) Saturday, Sunday, or legal holidays. Payments due on a Saturday, Sunday, or legal holiday under ORS 187.010 and 187.020 may be paid on the last working day before, or the first working day after, the Saturday, Sunday, or legal holiday. Subsequent payments may revert back to the payment schedule in place before the Saturday, Sunday, or legal holiday.¶
(3) Withheld compensation. Compensation withheld under ORS 656.268(13) and (14), and ORS 656.596(2), will not be considered late if the insurer notifies the worker in writing why benefits are being withheld and the amount that must be offset before any further benefits are payable.¶
(4) Timely payment of temporary disability. Insurers must timely process the first payment of temporary disability compensation. The first payment of temporary disability on a claim must also include all temporary disability benefits due as of the date of payment, unless there is a reasonable basis to exclude those benefits at the time the payment issued. The director may assess a penalty under OAR 436-060-0200 against an insurer that does not make the first payment of temporary disability under the time frames of this section, or does not accurately report timeliness of first payment information.¶
(a) The payment of temporary disability benefits must be made no later than the 14th day after:¶
(A) The date of the employer's notice or knowledge of the claim and of the worker's disability, if the attending physician or authorized nurse practitioner has authorized temporary disability compensation. Temporary disability accrued before the date of the employer's notice or knowledge of the claim is due within 14 days of claim acceptance;¶
(B) The date the attending physician or authorized nurse practitioner authorizes temporary disability, if the authorization is more than 14 days after the date of the employer's notice or knowledge of the claim and of the worker's disability;¶
(C) The start of authorized vocational training under ORS 656.268(10), if the insurer has previously closed the claim;¶
(D) The date the insurer receives medical evidence supported by objective findings that shows the worker is unable to work due to a worsening of the compensable condition under ORS 656.273;¶
(E) The date of any director's order, including, but not limited to, a reconsideration order, that orders payment of temporary disability. If the insurer has appealed a reconsideration order, the appeal stays payment of temporary disability benefits except those that accrue from the date of the order, under ORS 656.313;¶
(F) The date of a notice of claim closure issued by the insurer that finds the worker entitled to temporary disability;¶
(G) The date a notice of closure is set aside by a reconsideration order;¶
(H) The date any litigation authorizing retroactive temporary disability becomes final. Temporary disability accruing from the date of the order must begin no later than the 14th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the board is the signature date, and from the courts, it is the date of the appellate judgment;¶
(I) The date the director refers a claim to the insurer for processing under ORS 656.029;¶
(J) The date the director refers a noncomplying employer claim to an assigned claims agent under ORS 656.054;¶
(K) The date a claim disposition agreement is disapproved by the Worker's Compensation Board or administrative law judge, if temporary disability benefits are otherwise due;¶
(L) The date the director designates a paying agent under ORS 656.307;¶
(M) The date a claim is reclassified from nondisabling to disabling, if temporary disability is due and payable; or¶
(N) The date an insurer voluntarily rescinds a denial of a disabling claim.¶
(b) Subsequent payments of temporary disability benefits must~~:¶~~
~~(A) Be made a~~ be made:¶

(A) At least once each 14 days~~, unless the employer is making payments under OAR 436-060-0020(1) and the payments are made concurrently with the payroll schedule of the employer; and~~¶
~~(B) Include all benefits due for the period ending no more than seven days~~ and include all benefits due for the period ending no more than seven days before the payment date; or¶
(B) In accordance with the employer's payroll schedule and pay period. If temporary disability benefits are paid under this paragraph, the insurer's claim file must include written documentation of the payroll schedule and pay period before the payment ~~date~~s are issued.¶
(5) Timely payment of permanent disability.¶
(a) The first payment of permanent disability must be paid no later than the 30th day after:¶
(A) The date of a notice of claim closure issued by the insurer;¶
(B) The date of any litigation order that orders payment of permanent total disability. Permanent total disability benefits accruing from the date of the order must begin no later than the 30th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the board is the signature date, and from the courts, it is the date of the appellate judgment;¶
(C) The date of any director's order, including, but not limited to, a reconsideration order, that orders payment of compensation for permanent disability;¶
(D) The date any litigation order authorizing permanent partial disability becomes final;¶
(E) The date a claim disposition agreement is disapproved by the board or administrative law judge, if permanent disability benefits are otherwise due; or¶
(F) The date authorized training ends if the worker is medically stationary and any previous award remains unpaid, under ORS 656.268(10) and OAR 436-060-0040(3).¶
(b) Subsequent payments of permanent disability must be made on a regular and predictable monthly schedule.¶
(A) The insurer may adjust the monthly payment schedule, but must inform the worker or beneficiary before making the adjustment.¶
(B) No payment period may exceed one month without the director's approval.¶
(6) Timely payment of death benefits.¶
(a) Payment of bills submitted under OAR 436-060-0075(1) must be made no later than the 30th day after the date of the insurer's receipt the bill, or the date of claim acceptance, whichever is later.¶
(b) The first payment of monthly benefits to eligible beneficiaries under OAR 436-060-0075 must be paid no later than the 30th day after:¶
(A) The date of a notice of acceptance issued by the insurer; or¶
(B) The date of any litigation order that orders death benefits. Death benefits accruing from the date of the order must begin no later than the 30th day after:¶
(i) The signature date of an order from the board; or¶
(ii) The date of an appellate judgment from the courts.¶
(c) Subsequent payments of monthly benefits to eligible beneficiaries under OAR 436-060-0075 must be made on a regular and predictable schedule, subject to the following:¶
(A) The insurer may adjust the monthly payment schedule, but must inform the beneficiary before making the adjustment; and¶
(B) No payment period may exceed one month without the director's approval.¶
(d) Notwithstanding subsection (c), the insurer may make a payment in advance with the consent of the beneficiary.¶
(e) Payment of monthly benefits due to a worker's death during a period of permanent total disability under OAR 436-060-0075(7) must follow the monthly schedule established under subsection (5)(b) of this rule.¶
(7) Notice to worker or beneficiary regarding payments. The insurer must provide an explanation in writing to the worker or beneficiary when the benefit amount, time period covered, or payment schedule changes, and must:¶
(a) Notify the worker or beneficiary in writing of the specific purpose and the time period covered by each payment of temporary disability benefits; and¶
(b) Notify the worker or beneficiary in writing of the specific purpose of the payment, the schedule of future payments, and the time period each payment will cover with the first payment of permanent disability or death benefits. The insurer is not required to provide an explanation in writing with each subsequent permanent disability or death benefit payment.¶
(8) Maintenance of records. The insurer must maintain records of compensation paid for each claim in which benefits are due and payable.¶
(9) Request for reimbursement. If the worker submits a request for reimbursement, the insurer must respond as required under OAR 436-009-0025(1).¶
(10) Claim disposition agreements. Any amounts due under a claim disposition agreement must be paid no later than the 14th day after the board or administrative law judge provides notice of its approval under OAR 438-009-0028, unless otherwise stated in the agreement.¶

(11) Claims under other jurisdictions. When a worker has a claim under the workers' compensation law of another state, territory, province or foreign nation for the same injury or occupational disease as the claim filed in Oregon:¶
(a) The worker is entitled to the full amount of compensation due under Oregon law;¶
(b) The total amount paid or awarded under the other jurisdiction's law must be credited against the compensation due under Oregon law;¶
(c) If Oregon compensation is more than the compensation paid or awarded under the other jurisdiction's law, or compensation paid the worker under another law is recovered from the worker, the insurer must pay any unpaid compensation to the worker up to the amount required by the claim under Oregon law;¶
(d) Upon learning that the worker has a claim under the jurisdiction of another workers' compensation law, the insurer must request written documentation of the amount paid or awarded to the worker; and¶
(e) Payment under this section is due within 14 days of receipt of written documentation supporting the underpayment of Oregon compensation.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.126, ORS 656.204, ORS 656.208, ORS 656.262(4), ORS 656.268(10), ORS 656.273, ORS 656.278, ORS 656.289, ORS 656.307, ORS 656.313

AMEND: 436-060-0155

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0155 is amended to specify director referrals of penalty issues under ORS 656.262(11) may be discretionary, and the determination of whether to transfer a request to the board is solely within the authority of the director.

CHANGES TO RULE:

436-060-0155
Penalty to Worker for Untimely Processing ¶

(1) General. If the insurer unreasonably delays or unreasonably refuses to pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim:¶
(a) The director may require the insurer to pay:¶
(A) A penalty, payable to the worker, of up to 25 percent of the amounts then due, determined by the matrix attached to these rules in Appendix "B." When there are no "amounts then due" upon which to assess a penalty, no penalty will be issued under this rule; and¶
(B) A fee to the worker's attorney under ORS 656.262(11) and OAR 436-001-0420.¶
(b) For the purpose of this rule, and the matrix attached to these rules in Appendix "B," a "violation" is:¶
(A) The late payment or the nonpayment of any single payment due;¶
(B) A continuous underpayment, such as with yearly cost of living increases for temporary disability compensation. In the case of a continuous underpayment, all prior underpayments will be considered as one violation, regardless of when the first underpayment occurred; or¶
(C) The late issuance of an acceptance or denial notice under OAR 436-060-0140(2).¶
(2) Requests for penalties and attorney fees. Requests for penalties and attorney fees under this rule must:¶
(a) Be made in writing;¶
(b) State, in the request, what benefits have been delayed or remain unpaid; and¶
(c) Be mailed or delivered to the division within 180 days of the date of the alleged violation. For the purpose of this rule, the date of the alleged violation is:¶
(A) For the late payment or nonpayment of any single payments, the date payment was due;¶
(B) For a continuous underpayment, the date of the last underpayment; or¶
(C) For a late issuance of an acceptance or denial notice, the date the notice was due under OAR 436-060-0140(2).¶
(3) Required response from the insurer. When notified by the director that additional amounts may be due to the worker as a penalty under this rule:¶
(a) The insurer must respond in writing to the division:¶
(A) The response must include a reason for the delay, and any additional information or documentation requested by the director;¶
(B) The response must be mailed or delivered to the division within 14 days of the mailing date of the director's inquiry letter; and¶
(C) Copies of the response, including any attachments, must be simultaneously sent to the worker and the worker's attorney, if any;¶
(b) If the insurer fails to meet the requirements of this section, the director may assess a civil penalty under OAR 436-060-0200.¶
(4) Jurisdiction over proceedings. The director has exclusive jurisdiction when the assessment and payment of penalties and attorney fees described in ORS 656.262(11) ~~are~~is the ~~only~~sole issue~~s~~ of the proceedings between the parties. ~~T~~¶
(a) If the director ~~will not issue an order assessing a penalty or~~receives a request for penalties and attorney fees under this rule ~~when the same parties have initiated proceedings before the board.¶~~
~~(a) If the director receives a request for penalties and attorney fees under this rule, and is aware of proceedings between the parties be~~, and is aware that a hearing has been requested before the board on other issues, the director may transfer the request to the board. Factors the director will consider in determining whether to transfer the request include, but are not limited to, the status of the hearing and the date set fore the ~~board, the director will re~~hearing. The determination of whether to transfer ~~the~~a request to the board. ~~.~~ is solely within the authority of the director. ¶
(b) If the director has not been made aware of the proceeding before the board and issues a penalty order that becomes final, the director's penalty will stand.¶
(5) Timely payment of penalties. Penalties ordered under this rule must be paid to the worker no later than the

30th day after the date of the order, unless the order is appealed. If the order is appealed and later upheld, the penalty will be due within 14 days of the date the order upholding the penalty becomes final. If the insurer does not pay penalties in a timely manner the insurer will be subject to civil penalties under OAR 436-060-0200.¶
(6) Dispute resolution. Disputes regarding unreasonable delay or unreasonable refusal to pay compensation, attorney fees or costs, or unreasonable delay in acceptance or denial of a claim may be resolved by the parties.¶
(a) In cases where the director has exclusive jurisdiction under section (4) of this rule, and the violations occurred within the last 180 days as described in subsection (2)(c) of this rule, then the parties must submit a stipulation to the division for approval. The stipulation must specify:¶
(A) The benefits, attorney fees, or costs delayed and the amounts;¶
(B) The time periods involved;¶
(C) If applicable, the name of the medical providers and the dates of services relating to medical bills;¶
(D) The amount of the penalty not to exceed 25 percent of the amounts then due under ORS 656.262(11)(a); and¶
(E) The attorney fees, if applicable.¶
(b) Any other agreements between the parties to pay a penalty or attorney fee must have a stipulation approved by the director to be acknowledged as a violation as it applies to the matrix in Appendix "B" of these rules. [See attached table.]¶
(c) Payment of a penalty due under this section is due within 14 days after the date the director approves the stipulation, unless otherwise stated in the stipulation. If the insurer does not pay penalties in a timely manner the insurer will be subject to civil penalties under OAR 436-060-0200.
Statutory/Other Authority: ORS 656.262(11), 656.704, 656.726(4), 656.745
Statutes/Other Implemented: ORS 656.262(11), 656.704, 656.745

AMEND: 436-060-0170

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0170 is amended to:

-Clarify insurers may recover overpayments of benefits as specified under ORS 656.268 (12), (13), (14), and (16).

-Specify that the director, through its assigned processing administrator, may recover overpayments of supplemental disability benefits, or may require the insurer to do so.

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(12), (13), (14), and (16), unless authority is granted by an administrative law judge or the board.¶
(2) Benefits due a worker. An insurer may recover an overpayment from any benefits currently due on any claim the worker has with that insurer. The insurer must explain in writing the reason, the amount, and the method of recovery to the worker and the worker's attorney, if any, or to the worker's beneficiaries.¶
(3) Permanent partial disability offsets. When overpaid benefits are offset against monthly permanent partial disability award payments, the insurer must recover the benefits from the total amount of the award. The insurer must pay out the remainder of the award at 4.35 times the temporary total disability rate, or at least $108.75, starting with the first month's payment.¶
(4) Supplemental disability benefits.¶
The director, through its assigned processing administrator described under OAR 436-060-0035(2)(d), may recover overpayments of supplemental disability benefits under the same conditions provided under ORS 656.268(12), (13), (14), and (16), or may require the insurer to do so. If the insurer recovers an overpayment on behalf of the assigned processing administrator, the insurer must reimburse the assigned processing administrator.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.268(12) (13),(14), & (16) ~~(OL2022, ch. 73, sections 4 & 5)~~

AMEND: 436-060-0180

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0180 is amended to:

-Add a definition of the of term “earliest claim,”

-Specify that insurers must provide the earliest claim date and average weekly wage when requesting a paying agent designation.

-Specify that insurers must respond to the director’s request for clarification within 14 days of the “insurer’s date of receipt.”

-Specify that if the director cannot determine the claim with the lowest compensation based on the factors in section (9), the director may consider other information to determine the claim with the lowest compensation.

-Revise the terminology used in regards to permanent partial disability and add a reference to Bulletin 111.

CHANGES TO RULE:

436-060-0180
Designation and Responsibility of a Paying Agent ¶

(1) For the purpose of this rule:¶
(a) "Compensable injury" means an accidental injury or damage to a prosthetic appliance, or an occupational disease arising out of and in the course of employment with any Oregon employer, and which requires medical services or results in disability or death.¶
(b) "Exposure" means a specific incident or period during which a compensable injury may have occurred.¶
(c) "Responsibility" means liability under the law for the acceptance and processing of a compensable claim.¶
(d) "Earliest claim" means the earliest date of:¶
(A) A written request for compensation from a subject worker or someone on the worker's behalf; or¶
(B) The subject employer's notice or knowledge of the compensable injury.¶
(2) General. The director will designate by order which insurer must pay a claim if the employers and insurers admit that the claim is otherwise compensable, and where there is an issue regarding:¶
(a) Which subject employer is the true employer of the worker;¶
(b) Which of more than one insurer of a certain employer is responsible for payment of compensation to the worker;¶
(c) Which of two or more employers or their insurers is responsible for paying compensation for one or more on-the-job injuries or occupational diseases; or¶
(d) Which of two or more employers is responsible when there is joint employment.¶
(3) Own motion claims. With the consent of the board, own motion claims under ORS 656.278(1) are subject to this rule.¶
(4) Determination of compensability. Upon learning of any of the issues described in section (2) of this rule, the insurer must expedite the processing of the claim by immediately investigating the claim to determine responsibility and whether the claim is otherwise compensable.¶
(a) For the purposes of this rule, insurers identified in a potential responsibility dispute under ORS 656.307 must, upon request, share claim related medical reports and other information pertinent to the injury without charge in order to expedite claim processing.¶
(b) The act of the worker applying for compensation benefits from any employer identified as a party to a responsibility dispute constitutes authorization for the involved insurers to share the pertinent information in accordance with the criteria and restrictions provided in OAR 436-060-0017 and 436-010-0240.¶
(c) Copies of claims documents must be mailed under the time frames established in OAR 436-060-0017(5).¶
(d) An insurer that shares information under this rule bears no legal liability for disclosure of the information.¶
(5) Notification of affected insurers. Upon learning of any of the issues described in section (2) of this rule, the insurer must immediately notify any other affected insurers of the situation. Such notice must identify the compensable injury and include a copy of all medical reports and other information pertinent to the injury. The notice must identify each period of exposure that the insurer believes responsible for the compensable injury by the following:¶
(a) Name of employer;¶
(b) Name of insurer;¶
(c) Specific date of injury or period of exposure; and¶
(d) Claim number, if assigned.¶

(6) Request for designation of a paying agent. Upon deciding that the responsibility for an otherwise compensable injury cannot be determined, the insurer must request designation of a paying agent from the director in writing and mail a copy of the request to the worker and the worker's attorney, if any.¶
(a) The insurer may not attach the request to, or include the request in, any form or report the insurer is required to submit under OAR 436-060-0011 or in the denial letter to the worker required by OAR 436-060-0140.¶
(b) The request, or agreement to designation of a paying agent, is not an admission that the insurer is responsible for the compensable injury; it is solely an assertion that the injury is compensable against a subject Oregon employer.¶
(c) The insurer's written request must contain the following information:¶
(A) Identification of the compensable injuries or occupational diseases;¶
(B) That the insurer is requesting designation of a paying agent under ORS 656.307;¶
(C) That the insurer acknowledges the claim is otherwise compensable;¶
(D) That responsibility is the only issue;¶
(E) Identification of the specific claims or exposures involved by:¶
(i) Employer;¶
(ii) Insurer;¶
(iii) Date of injury or specific period of exposure; and¶
(iv) Claim number, if assigned;¶
(F) Acknowledgment that medical reports and other material pertinent to the injury have been provided to the other parties; ~~and~~¶
(G) Confirmation the worker has been advised of the actions being taken on the worker's claim;¶
(H) The worker's average weekly wage, as calculated under OAR 436-060-0025; and¶
(I) The earliest claim date.¶
(d) The director will not designate a paying agent when:¶
(A) It has not been determined if the injury is compensable against a subject Oregon employer;¶
(B) An insurer included in the question of responsibility opposes designation of a paying agent because it has received no claim; or¶
(C) The 60 day appeal period of a denial expired and:¶
(i) No request for hearing had been received by the board; or¶
(ii) No request for a designation of paying agent order had been received by the director.¶
(7) Failure to respond to request for clarification. When notified by the director that there is a reasonable doubt as to the status of the claim or intent of a denial, the insurer must provide written clarification to the director, the worker, the other insurers involved, and other interested parties within ~~2~~14 days of the ~~mailing date~~insurer's date of receipt of the notification. If an insurer fails to respond timely or provides an inadequate response (e.g., failing to answer specific questions or provide requested documents), the director may assess a civil penalty under OAR 436-060-0200.¶
(8) Insurer responsibilities. Insurers receiving notice from the director of a worker's request for designation of a paying agent must immediately process the request in accordance with sections (4) through (6) of this rule.¶
(9) Factors for designation. ¶
(a) Upon receipt of written acknowledgment from the insurers that the only issue is responsibility for an otherwise compensable injury claim, the director will issue an order designating a paying agent under ORS 656.307. The director will designate the insurer with the lowest compensation considering the following factors:¶
(~~a~~A) The claim with the lowest temporary total disability rate;¶
(~~b~~B) If the temporary total disability rates and the ~~rates per degree~~dollar rates of permanent partial disability in Bulletin 111 are the same, the earliest claim;¶
(~~c~~C) If there is no temporary disability or the temporary total disability rates are the same, but the ~~rates per degree~~dollar rates of permanent partial disability in Bulletin 111 are different, the claim with the lowest ~~rate per degre~~dollar rate of permanent partial disability;¶
(~~d~~D) If one or more claims have disposed of benefits in accordance with ORS 656.236(1), the claim providing the lowest compensation not released by the claim disposition agreement;¶
(eE) If one claim is under own motion jurisdiction, that claim, even if it is not the claim with the lowest temporary total disability rate; and¶
(~~f~~F) If more than one claim is under own motion jurisdiction, the own motion claim with the lowest temporary total disability rate.¶
(b) If the claim with the lowest compensation cannot be determined under (a) of this section, the director may consider other information to designate a paying agent.¶
(10) Referral to the Worker's Compensation Board. By copy of its order, the director will refer the matter to the board to set a proceeding under ORS 656.307 to determine which insurer is responsible for paying benefits to the worker.¶

(11) Responsibilities of designated paying agent. The designated paying agent must process the claim as an accepted claim through claim closure under OAR 436-030-0015 unless it is relieved of the responsibility by an order of the administrative law judge or resolution through mediation or arbitration under ORS 656.307(6).¶
(a) The parties to an order under this section may not settle any part of a claim under ORS 656.236 or 656.289, except to resolve the issue of responsibility, unless prior approval and agreement is obtained from all potential responsible insurers.¶
(b) Resolution of a dispute by mediation or arbitration by a private party cannot obligate the Consumer and Business Services Fund without the director's prior approval.¶
(c) The Consumer and Business Services Fund is not obligated when one party declines to participate in a legitimate settlement conference under an ORS 656.307 order.¶
(d) Compensation paid under the order must include all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries. The payment of temporary disability due must be for periods subsequent to periods of disability already paid by any insurer.¶
(12) Change in compensability or claims status. After a paying agent is designated, if any of the insurers determine compensability may be an issue at hearing, the insurer must notify the director.¶
(a) Any insurer must notify the director and all parties to the order of any change in claim acceptance status after the designation of a paying agent.¶
(b) When the director receives notification of a change in the acceptance of a claim or notification that compensability is an issue after designation of a paying agent, the director will order termination of any further benefits due from the original order designating a paying agent.
Statutory/Other Authority: ORS 656.307, ORS 656.726(4), ORS 656.745
Statutes/Other Implemented: ORS 656.307, ORS 656.745, ORS 656.308

AMEND: 436-060-0500

NOTICE FILED DATE: 03/27/2024

RULE SUMMARY: Rule 0500 is amended to specify that invalid or incorrect payments may be identified at times outside of audits.

CHANGES TO RULE:

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

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

Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.210