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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

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

FILED
10/10/2019 5:03 PM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Implementation of legislation; alignment of workers' compensation rules with workers' compensation statutes

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/27/2019 11:55 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

CONTACT: Fred Bruyns
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350 Winter Street NE
PO Box 14480
Salem,OR 97309

Filed By:
FREDERICK BRUYNS
Rules Coordinator

HEARING(S)

Auxilary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/21/2019
TIME: 10:00 AM
OFFICER: Fred Bruyns
ADDRESS: Labor & Industries Building,
Room F
350 Winter Street NE
Salem, OR 97301
SPECIAL INSTRUCTIONS:
Dial-in number is 1-213-787-0529;
Access code is 9221262#.

NEED FOR THE RULE(S):

Rule amendments are needed primarily to implement legislation passed in 2019 and to align the wording of certain rules with the wording of governing statutes.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Enrolled HB 2087 (2019). Enrolled HB 3146 (2019). Written advice. These documents are available for public inspection upon request to the Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879. Please contact Fred Bruyns, rules coordinator, 503-947-7717, fred.h.bruyns@oregon.gov.

FISCAL AND ECONOMIC IMPACT:

Proposed rule amendments to implement HB 2087 are projected to have a minimal fiscal impact on the agency. Any increased short-term work for implementation will be accomplished using existing resources, and any future time saved will be reallocated to other job functions.

The agency has no immediate plans to increase per-violation penalties, and future increases, if any, will be gradual and applied only as needed to promote compliance with laws and rules. Over time, there may be a small increase in civil penalty revenue to the Workers' Benefit Fund, though it is not possible to predict the amount as it will depend on the future behavior of regulated parties. A sustained change in civil penalty revenue will be considered when determining the cents-per-hour assessment on employers and employees that is the fund's primary revenue source.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

a. The agency estimates that proposed rule changes will not have a significant effect on costs to state agencies for compliance with the rules.

b. The agency estimates that proposed rule changes will not have a significant effect on costs to units of local government for compliance with the rules, except for cities and counties that are self-insured employers. See part c. for projected effects for self-insured employers.

c. The agency estimates that proposed rule changes may have a minor impact on costs to the public. HB 2087 raised the maximum civil penalty against an insurer, self-insured employer, or service company for certain violations of statutes, rules or orders of the director from $2,000 to $4,000 per violation, and increased the maximum, aggregated penalties from $10,000 in any three-month period to $180,000 during a calendar year. The agency has no immediate plans to increase per-violation penalties, and future increases, if any, will be gradual and applied only as needed to promote compliance with laws and rules. Over time, there may be a small increase in the aggregate amount of civil penalties issued, especially for the few insurers that have reached the current dollar limit for penalties, though it is not possible to predict the amount as that will depend on future compliance with laws, rules, and orders of the director.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:

The businesses primarily affected by these rules are workers' compensation insurers, self-insured employers, and self-insured employer groups. These entities tend to be large employers and not small businesses as defined by ORS 183.310. Service companies could be affected; approximately 25 service companies process Oregon workers' compensation claims, and of these fewer than five are small businesses.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

The agency projects that proposed rule amendments will not increase costs for reporting, recordkeeping, professional services, or other administrative activities required for compliance.

c. Equipment, supplies, labor and increased administration required for compliance:

The agency projects that proposed rule amendments will not increase costs for equipment, supplies, labor, or administration required for compliance.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

The agency posted draft rules and an issues document to its website and sent a request for written advice to more than

4,000 stakeholders, including many who work for or own small businesses.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? NO IF NOT, WHY NOT?

Draft rule amendments were limited mostly to what was essential to implement passed legislation and otherwise align the wording of rules and statutes. The agency asked more than 4,000 stakeholders to review draft rules and issues and offer written advice, and also asked about interest in a meeting to discuss draft rule amendments. The agency did not receive any requests to form a committee or schedule a meeting.

RULES PROPOSED:
436-009-0008, 436-009-0060, 436-010-0008, 436-010-0340, 436-015-0120, 436-055-0110, 436-060-0025, 436-060-0200, 436-070-0050, 436-085-0060, 436-110-0310, 436-140-0120

AMEND: 436-009-0008

RULE SUMMARY: Amended OAR 436-009-0008 clarifies the types of disputes that are in the jurisdiction of the Workers' Compensation Board.

CHANGES TO RULE:

436-009-0008
Request for Review before the Director ¶

(1) General.¶
(a) ~~Administrative review before the director:¶~~
~~(A)~~ Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all disputes concerning medical fees, non-payment of compensable medical bills, and medical service and treatment disputes arising under ORS 656.245, 656.247, 656.248, 656.260, 656.325, and 656.327. Disputes about whether a medical service provided after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c), or whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review before the director.¶
(~~B~~b) As provided in ORS 656.704(3)(b), the following disputes are in the jurisdiction of the board and will be transferred:¶
(A) A dispute that requires a determination of the compensability of the medical condition for which medical services are proposed; and¶
(B) A dispute that requires a determination of whether a sufficient causal relationship exists between medical services and an accepted claim.¶
(c) A party does not need to be represented to participate in the administrative review before the director.¶
(~~C~~d) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed.¶
(be) ~~Except for disputes regarding interim medical benefits under ORS 656.247, when there is a formal denial of the compensability of the underlying claim, or a denial of the causal relationship between the medical service or treatment and the accepted condition or the underlying condition, the parties may file a request for hearing with the board to resolve the compensability issue~~A request for administrative review under this rule may also be filed as prescribed in OAR 438-005.¶
(2) Time Frames and Conditions. The following time frames and conditions apply to requests for administrative review before the director under this rule:¶
(a) For MCO-enrolled claims, a party that disagrees with an action or decision of the MCO must first use the MCO's dispute resolution process. If the party does not appeal the MCO's decision using the MCO's dispute resolution process, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision absent a showing of good cause. When the aggrieved party is a represented worker,

and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision. When a party mistakenly sends an appeal of an MCO action or decision to the division, the division will forward the appeal to the MCO. The MCO must use the original mailing date of the appeal mistakenly sent to the division when determining timeliness of the appeal.¶
(b) For MCO-enrolled claims, if a party disagrees with the final action or decision of the MCO, the aggrieved party must request administrative review before the director within 60 days of the MCO's final decision. When the aggrieved party is a represented worker, and the worker's attorney had given written notice of representation to the insurer at the time the MCO issued its decision, the 60-day time frame begins when the MCO issues its final decision to the attorney. If a party has been denied access to the MCO dispute resolution process, or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process. If the MCO does not have a process for resolving a particular type of dispute, the insurer or the MCO must advise the medical provider or worker that they may request review before the director.¶
(c) For claims not enrolled in an MCO, or for disputes that do not involve an action or decision of an MCO:¶
(A) A worker must request administrative review before the director within 90 days of the date the worker knew, or should have known, there was a dispute over the provision of medical services. If the worker is represented, and the worker's attorney has given notice of representation to the insurer, the 90-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute.¶
(B) A medical provider must request administrative review within 90 days of the mailing date of the most recent explanation of benefits or a similar notification the provider received regarding the disputed service or fee. Rebillings without any relevant changes will not provide a new 90-day period to request administrative review.¶
(C) An insurer must request administrative review within 90 days of the date action on the bill was due under OAR 436-009-0030.¶
(D) For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, whichever occurs last. ~~A request for administrative review under this rule may also be filed as prescribed in OAR chapter 438, division 005.~~¶
(d) Within 180 days of the date a bill is paid, an insurer may request a refund from a provider for any amount it determines was overpaid for a compensable medical service. If the provider does not respond to the request, or disagrees that a service was overpaid, the insurer may request director review within 90 days of requesting the refund.¶
(e) Medical provider bills for treatment or services that are under review before the director are not payable during the review.¶
(3) Form and Required Information.¶
(a) Requests for administrative review before the director should be made on Form 2842 as described in Bulletin 293. When an insurer or a worker's representative submits a request without the required information, the director may dismiss the request or hold initiation of the administrative review until the required information is submitted. Unrepresented workers may ask the director for help in meeting the filing requirements.¶
(A) The requesting party must simultaneously notify all other interested parties and their representatives, if known, of the dispute. The notice must:¶
(i) Identify the worker's name, date of injury, insurer, and claim number;¶
(ii) Specify the issues in dispute and the relief sought; and¶
(iii) Provide the specific dates of the unpaid disputed treatment or services.¶
(B) If the request for review is submitted by either the insurer or the medical provider, it must state specific codes of services in dispute and include enough documentation to support the request, including copies of original bills, chart notes, bill analyses, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to review the dispute. The insurer or medical provider requesting review must provide all involved parties a copy of:¶

(i) The request for review;¶
(ii) Any attached supporting documentation; and¶
(iii) If known, an indication of whether or not there is an issue of causation or compensability ~~of the underlying claim or condition~~under subsection (1)(b) of this rule.¶
(b) In addition to medical evidence relating to the dispute, all parties may submit other relevant information, including written factual information, sworn affidavits, or legal argument~~,~~ for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain additional evidence consistent with statute, such as pertinent medical treatment and payment records. The director may also interview parties to the dispute~~,~~ or consult with an appropriate committee of the medical provider's peers. When a party receives a written request for additional information from the director, the party must respond within 14 days.¶
(c) When a request for administrative review is filed under ORS 656.247, the insurer must provide a record packet, at no charge, to the director and all other parties or their representatives as follows:¶
(A) The packet must include a complete copy of the worker's medical record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top. The packet must include the following notice in bold type:¶
We hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order that could affect reimbursement for the disputed medical service(s).¶
(B) If the insurer requests review, the packet must accompany the request~~,~~ with copies sent simultaneously to the other parties.¶
(C) If the requesting party is other than the insurer~~,~~ or if the director has initiated the review, the director will request the record from the insurer. The insurer must provide the record within 14 days of the director's request as described in this rule.¶
(D) If the insurer fails to submit the record in the time and format specified in this rule, the director may sanction the insurer under OAR 436-010-0340.¶
(4) Dispute Resolution by Agreement (Alternative Dispute Resolution).¶
(a) A dispute may be resolved by agreement between the parties to the dispute. The agreement must be in writing and approved by the director. The director may issue a letter of agreement instead of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:¶
(A) A party fails to honor the agreement;¶
(B) The agreement was based on misrepresentation;¶
(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or¶
(D) All parties request revision or reinstatement of the dispute.¶
(b) Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney.¶
(5) Director Order and Reconsideration.¶
(a) The director may, on the director's own motion, reconsider or withdraw any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new information that could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request must be received by the director before the administrative order becomes final.¶
(b) During any reconsideration of the administrative order, the parties may submit new material evidence consistent with this rule and may respond to such evidence submitted by others.¶
(c) Any party requesting reconsideration or responding to a reconsideration request must simultaneously notify all other interested parties of its contentions and provide them with copies of all additional information presented.¶

(d) Attorney fees in administrative review will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 through 436-001-0440.¶
(6) Hearings.¶
(a) Any party that disagrees with an action or administrative order under these rules may obtain review of the action or order by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order under ORS 656.245, 656.248, 656.260, or 656.327, or within 60 days of the mailing date of an order under ORS 656.247. OAR 436-001 applies to the hearing.¶
(b) In the review of orders issued under ORS 656.245(3) or 656.247, no new medical evidence or issues will be admitted at hearing. In these reviews, an administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.¶
(c) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254 or 656.745 may request a hearing by the board as follows:¶
(A) A written request for a hearing must be mailed or submitted to the division. The request must specify the grounds upon which the proposed order or assessment is contested.¶
(B) The request must be mailed or submitted to the division within 60 days after the mailing date of the order or notice of assessment.¶
(C) The division will forward the request and other pertinent information to the board.¶
(7) Other Proceedings.¶
(a) Director's administrative review of other actions not covered under sections (1) through (6) of this rule: Any party seeking an action or decision by the director, or any party aggrieved by an action taken by another party, may request administrative review before the director. Any party may request administrative review as follows:¶
(b) A written request for review must be sent to the division within 90 days of the disputed action and must specify the grounds upon which the action is contested.¶
(c) The division may require and allow such input and information as it deems appropriate to complete the review.
Statutory/Other Authority: ORS 656.704, 656.726(4)
Statutes/Other Implemented: ORS 656.704

AMEND: 436-009-0060

RULE SUMMARY: Amended OAR 436-009-0060 removes an incorrect citation to ORS 656.260, because that statute is not relevant to director-required medical examinations or reviews.

CHANGES TO RULE:

436-009-0060
Oregon Specific Codes ¶

(1) Multidisciplinary Services.¶
(a) Services provided by multidisciplinary programs not otherwise described by CPT codes must be billed under Oregon specific codes.¶
(b) Bills using the multidisciplinary codes must include copies of the treatment record that specifies:¶
(A) The type of service rendered,¶
(B) The medical provider who provided the service,¶
(C) Whether treatment was individualized or provided in a group session, and¶
(D) The amount of time treatment was rendered for each service billed.¶
(2) Table of all Oregon Specific Codes (For OSC fees, see Appendix B, available from the agency.) See attached table.¶
(3) CARF / JCAHO Accredited Programs.¶
(a) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program will not be paid unless the program is accredited for that purpose by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).¶
(b) Organizations that have applied for CARF accreditation, but have not yet received accreditation, may receive payment for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. The organizations may provide multidisciplinary services under this section for a period of up to six months from the date CARF provided notice to the organization that the accreditation process has been initiated, or until such time as CARF accreditation has been received or denied, whichever occurs first.¶
(c) Notwithstanding OAR 436-009-0010(4)(a), program fees for services within a multidisciplinary program may be used based upon written pre-authorization from the insurer. Programs must identify the extent, frequency, and duration of services to be provided.¶
(d) All job site visits and ergonomic consultations must be preauthorized by the insurer.¶
Table is attached.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.248

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

436-009-0060 Oregon Specific Codes

* * * *

(2) Table of all Oregon Specific Codes (For OSC fees, see Appendix B.)

Service	OSC
Arbiter exam - level 1: A basic medical exam with no complicating factors.	AR001
Arbiter exam - level 2: A moderately complex exam that may have complicating factors.	AR002
Arbiter exam - level 3: A very complex exam that may have several complicating factors.	AR003
Arbiter exam – limited: A limited exam that may involve a newly accepted condition, or a partial exam.	AR004
Arbiter file review - level 1: A file review of a limited record.	AR021
Arbiter file review - level 2: A file review of an average record.	AR022
Arbiter file review - level 3: A file review of a large record or a disability evaluation without an exam.	AR023
Arbiter file review - level 4: A file review of an extensive record.	AR024
Arbiter file review - level 5: A file review of an extensive record with unique factors.	AR025
Arbiter report - level 1: A report that answers standard questions.	AR011
Arbiter report - level 2: A report that answers standard questions and complicating factors.	AR012
Arbiter report - level 3: A report that answers standard questions and multiple complicating factors.	AR013
Arbiter report - complex supplemental report: A report to clarify information or to address additional issues.	AR032
Arbiter report - limited supplemental report: A report to clarify information or to address additional issues.	AR031

Service	OSC
Closing exam: An exam to measure impairment after the worker's condition is medically stationary.	CE001
Closing report: A report that captures the findings of the closing exam.	CR001
Consultation – attorney: Time spent consulting with an insurer's attorney.	D0001
Consultation – insurer: Time spent consulting with an insurer.	D0030
Copies of medical records: Copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0001
Copies of medical records electronically: Electronic copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0002
Deposition time: Time spent being deposed by insurer's attorney, includes time for preparation, travel, and deposition.	D0002
Director required medical exam or review time: Services by a physician selected under ORS 656.327~~ or 656.260,~~ to review treatment, perform reasonable and appropriate tests, or examine the worker. Services must be paid at an hourly rate up to 6 hours for record review and exam.	P0001
Director required medical report: Preparation and submission of the report.	P0003
Director required review - complex case fee: Pre-authorized fee by the director for an extensive review in a complex case.	P0004
Director required exam – failure to appear: Patient fails to appear for a director required exam.	P0005
Ergonomic consultation - 1 hour (includes travel): Must be preauthorized by insurer. Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications.	97661
IME (independent medical exam): Report, addendum to a report, file review, or exam.	D0003

Service	OSC
IME – review and response: Insurer--requested review and response by treating physician; document time spent.	D0019
Interdisciplinary rehabilitation conference - 10 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97655
Interdisciplinary rehabilitation conferences – intermediate - 20 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97656
Interdisciplinary rehabilitation conferences – complex - 30 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97657
Interdisciplinary rehabilitation conferences – complex - each additional 15 minutes - up to 1 hour maximum: Each additional 15 minutes complex conference - up to 1 hour maximum.	97658
Interpreter mileage	D0041
Interpreter services – provided by a noncertified interpreter, excluding American Sign Language	D0004
Interpreter services – American Sign Language	D0005
Interpreter services - provided by a health care interpreter certified by the Oregon Health Authority, excluding American Sign Language	D0006
Job site visit - 1 hour (includes travel): Must be preauthorized by insurer. A work site visit to identify characteristics and physical demands of specific jobs.	97659
Job site visit - each additional 30 minutes	97660
Multidisciplinary conference – initial - up to 30 minutes	97670
Multidisciplinary conference - initial/complex - up to 60 minutes	97671

Service	OSC
Narrative – brief: Narrative by the attending physician or authorized nurse practitioner, including a summary of treatment to date and current status and, if requested, brief answers to one to five questions related to the current or proposed treatment.	N0001
Narrative – complex: Narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, treatment to date, current status, impairment, prognosis, and medically stationary information.	N0002
Nursing evaluation - 30 minutes: Nursing assessment of medical status and needs in relationship to rehabilitation.	97664
Nursing evaluation - each additional 15 minutes	97665
Nutrition evaluation - 30 minutes: Evaluation of eating habits, weight, and required modifications in relationship to rehabilitation.	97666
Nutrition evaluation - each additional 15 minutes	97667
PCE (physical capacity evaluation) - first level: This is a limited evaluation primarily to measure musculoskeletal components of a specific body part. These components include such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level generally requires 30 to 45 minutes of actual patient contact. A first level PCE is paid under OSC 99196, which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99196

Service	OSC
PCE - second level: This is a PCE to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish residual functional capacities for claim closure. This level generally requires not less than two hours of actual patient contact. The second level PCE is paid under OSC 99197, which includes the evaluation and report. Additional 15 minute increments may be added to measure additional body parts, to establish endurance and to project tolerances. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99197
PCE – each additional 15 minutes	99193
Physical conditioning - group - 1 hour: Conditioning exercises and activities, graded and progressive.	97642
Physical conditioning - group - each additional 30 minutes	97643
Physical conditioning – individual - 1 hour: Conditioning exercises and activities, graded and progressive.	97644
Physical conditioning – individual - each additional 30 minutes	97645
Professional case management – individual 15 minutes: Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician).	97654
Social worker evaluation - 30 minutes: Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome.	97668
Social worker evaluation – each additional 15 minutes	97669
Therapeutic education – individual - each additional 30 minutes	97650
Therapeutic education – individual - each additional 15 minutes	97651
Therapeutic education - group 30 minutes: Medical, psychosocial, nutritional, and vocational education dependent on needs and stated goals.	97652
Therapeutic education - group - each additional 15 minutes	97653
Vocational evaluation - 30 minutes: Evaluation of work history, education, and transferable skills coupled with physical limitations in relationship to return-to-work options.	97662
Vocational evaluation - each additional 15 minutes	97663

Service	OSC
WCE (work capacity evaluation): This is a residual functional capacity evaluation that generally requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. A WCE is paid under OSC 99198, which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report. Special emphasis should be given to: • The ability to perform essential physical functions of the job based on a specific job; • Analysis as related to the accepted condition; • The ability to sustain activity over time; and • The reliability of the evaluation findings.	99198
WCE – each additional 15 minutes	99193
Work simulation - group 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97646
Work simulation - group - each additional 30 minutes	97647
Work simulation - individual 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97648
Work simulation - individual - each additional 30 minutes	97649
WRME (worker requested medical exam): Exam and report.	W0001

*** * * ***

AMEND: 436-010-0008

RULE SUMMARY: Amended OAR 436-010-0008 clarifies the types of disputes that are in the jurisdiction of the Workers' Compensation Board.

CHANGES TO RULE:

436-010-0008
Request for Review before the Director ¶

(1) General.¶
(a) ~~Administrative review before the director:¶~~
~~(A)~~ Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all disputes concerning medical fees, non-payment of compensable medical bills, and medical service and treatment disputes arising under ORS 656.245, 656.247, 656.248, 656.260, 656.325, and 656.327. Disputes about whether a medical service provided after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c), or whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review before the director.¶
(~~B~~b) As provided in ORS 656.704(3)(b), the following disputes are in the jurisdiction of the board and will be transferred:¶
(A) A dispute that requires a determination of the compensability of the medical condition for which medical services are proposed; and¶
(B) A dispute that requires a determination of whether a sufficient causal relationship exists between medical services and an accepted claim.¶
(c) A party does not need to be represented to participate in the administrative review before the director.¶
(~~C~~d) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed.¶
(~~b~~e) All issues pertaining to disagreements about medical services within a managed care organization (MCO), including disputes under ORS 656.245(4)(a) about whether a change of provider will be medically detrimental to the worker, are subject to ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting an administrative review of the matter before the director.¶
~~(c) Except for disputes regarding interim medical benefits under ORS 656.247, when there is a formal denial of the compensability of the underlying claim, or a denial of the causal relationship between the medical service or treatment and the accepted condition or the underlying condition, the parties may file a request for hearing with the board to resolve the compensability issue.¶~~
(~~d~~f) The director may, on the director's own motion, initiate a review of medical services or medical treatment at any time.¶
(~~e~~g) If the director issues an order declaring an already rendered medical treatment or medical service inappropriate, or otherwise in violation of the statute or medical rules, the worker is not obligated to pay for such.¶
(h) A request for administrative review under this rule may also be filed as prescribed in OAR 438-005.¶
(2) Time Frames and Conditions.¶
(a) The following time frames and conditions apply to requests for administrative review before the director under this rule:¶
(A) For MCO-enrolled claims, a party that disagrees with an action or decision of the MCO must first use the MCO's dispute resolution process. If the party does not appeal the MCO's decision using the MCO's dispute resolution process, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision unless the party can show good cause. Good cause means circumstances that are outside the control of a party or circumstances that are considered to be extenuating by the division. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to

the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision. When a party mistakenly sends an appeal of an MCO action or decision to the division, the division will forward the appeal to the MCO. The MCO must use the original mailing date of the appeal mistakenly sent to the division when determining timeliness of the appeal.¶
(B) For MCO-enrolled claims, if a party disagrees with the final action or decision of the MCO, the aggrieved party must request administrative review before the director within 60 days of the MCO's final decision. When the aggrieved party is a represented worker, and the worker's attorney had given written notice of representation to the insurer at the time the MCO issued its decision, the 60-day time frame begins when the MCO issues its final decision to the attorney. If a party has been denied access to the MCO dispute resolution process, or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process. If the MCO does not have a process for resolving a particular type of dispute, the insurer or the MCO must advise the medical provider or worker that they may request review before the director.¶
(C) For claims not enrolled in an MCO, or for disputes that do not involve an action or decision of an MCO, the aggrieved party must request administrative review before the director within 90 days of the date the party knew, or should have known, there was a dispute. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 90-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due. For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, whichever occurs last. ~~A request for administrative review under this rule may also be filed as prescribed in OAR chapter 438, division 005.~~¶
(b) Medical provider bills for treatment or services that are under review before the director are not payable during the review.¶
(3) Form and Required Information.¶
(a) Requests for administrative review before the director should be made on Form 2842 as described in Bulletin 293. When an insurer or a worker's representative submits a request without the required information, the director may dismiss the request or hold initiation of the administrative review until the required information is submitted. Unrepresented workers may ask the director for help in meeting the filing requirements. The requesting party must simultaneously notify all other interested parties and their representatives, if known, of the dispute. The notice must:¶
(A) Identify the worker's name, date of injury, insurer, and claim number;¶
(B) Specify the issues in dispute and the relief sought; and¶
(C) Provide the specific dates of the unpaid disputed treatment or services.¶
(b) In addition to medical evidence relating to the dispute, all parties may submit other relevant information, including written factual information, sworn affidavits, or legal argument, for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain additional evidence consistent with statute, such as pertinent medical treatment and payment records. The director may also interview parties to the dispute, or consult with an appropriate committee of the medical provider's peers. When a party receives a written request for additional information from the director, the party must respond within 14 days.¶
(c) When a request for administrative review is filed under ORS 656.247, 656.260, or 656.327, the insurer must provide a record packet, at no charge, to the director and all other parties or their representatives as follows:¶
(A) The packet must include a complete copy of the worker's medical record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top. The packet must include the following notice in bold type:¶
We hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order that could affect reimbursement for the disputed medical service(s).¶
(B) If the insurer requests review, the packet must accompany the request, with copies sent simultaneously to the

other parties.¶
(C) If the requesting party is not the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer must provide the record within 14 days of the director's request as described in this rule.¶
(D) If the insurer fails to submit the record in the time and format specified in this rule, the director may sanction the insurer under OAR 436-010-0340.¶
(E) Except for disputes regarding interim medical benefits, the packet must include certification ~~stating~~ that there is or is not an issue of compensability ~~of the underlying claim or condition or stating that there is not an issue of compensability of the underlying claim or condition~~r causation under subsection (1)(b) of this rule. If the insurer issued a denial that has been reversed by the board or the Court of Appeals, the insurer must provide a statement regarding its intention, if known, to accept or appeal the decision.¶
(4) Physician Review (E.g., appropriateness). If the director determines a review by a physician is indicated to resolve the dispute, the director, under OAR 436-010-0330, may appoint an appropriate medical service provider or panel of providers to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. Notwithstanding ORS 656.325(1), if the worker is required by the director to submit to a medical exam as part of the administrative review process, the worker may refuse an invasive test without sanction.¶
(a) A single physician selected to conduct a review must be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment or service is being reviewed.¶
(b) When a panel of physicians is selected, at least one panel member must be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment or service is being reviewed.¶
(c) When such an exam of the worker is required, the director will notify the appropriate parties of the date, time, and location of the exam. Examinations will be at a place reasonably convenient to the worker, if possible. The parties must not directly contact the physician or panel unless it relates to the exam date, time, location, or attendance. If the parties have special questions they want addressed by the physician or panel, the questions must be submitted to the director for screening as to the appropriateness of the questions. Matters not related to the issues before the director are inappropriate for medical review and will not be submitted to the reviewing physician(s). The exam may include, but is not limited to:¶
(A) A review of all medical records and diagnostic tests submitted,¶
(B) An examination of the worker, and¶
(C) Any necessary and reasonable medical tests.¶
(5) Dispute Resolution by Agreement (E.g., Alternative Dispute Resolution).¶
(a) A dispute may be resolved by agreement between the parties to the dispute. The agreement must be in writing and approved by the director. The director may issue a letter of agreement instead of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:¶
(A) A party fails to honor the agreement;¶
(B) The agreement was based on misrepresentation;¶
(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or¶
(D) All parties request revision or reinstatement of the dispute.¶
(b) Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney.¶
(c) If the dispute does not resolve through mediation or alternative dispute resolution, the director will issue an order. If the dispute is not resolved by agreement and if the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order under ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical dispute exists, the party may appeal the order to the Workers' Compensation Board within 30 days of the mailing date of the order. Upon review, the order of the director may be modified only if it is not supported by substantial evidence in the record developed by the director.¶

(6) Director Order and Reconsideration.¶
(a) The director may, on the director's own motion, reconsider or withdraw any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new information that could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request must be received by the director before the administrative order becomes final.¶
(b) During any reconsideration of the administrative order, the parties may submit new material evidence consistent with this rule and may respond to such evidence submitted by others.¶
(c) Any party requesting reconsideration or responding to a reconsideration request must simultaneously notify all other interested parties of its contentions and provide them with copies of all additional information presented.¶
(d) Attorney fees in administrative review will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 through 436-001-0440.¶
(7) Hearings.¶
(a) Any party that disagrees with an action or administrative order under these rules may obtain review of the action or order by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the action or order under ORS 656.245, 656.248, 656.260, or 656.327, or within 60 days of the mailing date of an action or order under ORS 656.247. OAR 436-001 applies to the hearing.¶
(b) In the review of orders issued under ORS 656.245, 656.247, 656.260(15) or (16), or 656.327(2), no new medical evidence or issues will be admitted at hearing. In these reviews, an administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.¶
(c) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254 or 656.745 may request a hearing by the board as follows:¶
(A) A written request for a hearing must be mailed or submitted to the division. The request must specify the grounds upon which the proposed order or assessment is contested.¶
(B) The request must be mailed or submitted to the division within 60 days after the mailing date of the order or notice of assessment.¶
(C) The division will forward the request and other pertinent information to the board.¶
(8) Other Proceedings.¶
(a) Any party seeking an action or decision by the director, or any party aggrieved by an action taken by another party not covered under sections (1) through (7) of this rule, may request administrative review before the director.¶
(b) A written request for review must be sent to the division within 90 days of the disputed action and must specify the grounds upon which the action is contested.¶
(c) The division may require and allow such input and information as it deems appropriate to complete the review.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704

AMEND: 436-010-0340

RULE SUMMARY: Amended OAR 436-010-0340 –
- Implements House Bill (HB) 2087 (2019), which raised the limits for certain civil penalty maximums; references to specific dollar amounts are replaced by a reference to ORS 656.745(2); and
- Includes minor wording changes that enhance clarity.

CHANGES TO RULE:

436-010-0340
Sanctions and Civil Penalties ¶

(1) If the director finds any medical provider in violation of the medical reporting requirements established under ORS 656.245, 656.252, 656.254, or 656.325, or OAR 436-009 or 436-010, the director may impose one or more of the following sanctions:¶
(a) Reprimand by the director;¶
(b) Non-payment, reduction, or recovery of fees in part or whole for medical services provided;¶
(c) Referral to the appropriate licensing board;¶
(d) Civil penalty not to exceed $1,000 for each occurrence. In determining the amount of penalty to be assessed, the director will consider:¶
(A) The degree of harm inflicted on the worker or the insurer;¶
(B) Whether there have been previous violations; and¶
(C) Whether there is evidence of willful violations; or¶
(e) A penalty of $100 for each violation of ORS 656.325(1)(c)(C).¶
(2) If the medical provider fails to provide information under OAR 436-010-0240 within ~~fourteen~~14 days of receiving a request sent by certified mail or fax, penalties under this rule or OAR 436-015-0120 may be imposed.¶
(3) The director may impose a penalty of forfeiture of fees and a fine not to exceed $1,000 for each occurrence on any medical service provider who, under ORS 656.254, and 656.327, has been found to:¶
(a) Fail to comply with the medical rules;¶
(b) Provide medical services that are excessive, inappropriate, or ineffectual; or¶
(c) Engage in any conduct demonstrated to be dangerous to the health or safety of a worker.¶
(4) If the conduct as described in section (3) of this rule is found to be repeated and willful, the director may declare the medical provider ineligible for reimbursement for treating workers' compensation patients for a period not to exceed three years.¶
(5) A medical provider whose license has been suspended or revoked by the licensing board for violations of professional ethical standards may be declared ineligible for reimbursement for treating workers' compensation patients for a period not to exceed three years. A certified copy of the revocation or suspension order will be prima facie justification for the director's order.¶
(6) If a financial penalty is imposed on the medical provider for violation of these rules, the provider may not seek recovery of the penalty fees from the worker.¶
(7) If an insurer or worker believes sanctions under sections (1) or (2) of this rule are appropriate, either may submit a complaint in writing to the director.¶
(8) If the director finds an insurer in violation of the notification provisions of OAR 436-010 limiting medical services, the director may order the insurer to reimburse any affected medical providers for services provided until the insurer complies with the notification requirement. ~~Any penalty will be limited to the amounts listed in section (9) of this rule.¶~~
~~(9) If the director finds~~¶
(9) The director may assess a civil penalty under ORS 656.745(2) against an~~y~~ insurer ~~in~~that violat~~ion of statute~~es ORS chapter 656, OAR 436-009, OAR 436-010, or an order of the director~~, the insurer may be subject to penalties under ORS 656.745 of not more than $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, will be considered a~~

~~separate violation.¶~~
~~(10) The director may subjec.¶~~
(10) The director may impose a $100 penalty per occurrence under ORS 656.325 against a worker who fails to meet the requirements in OAR 436-010-0265(10) ~~to a $100 penalty per occurrence under ORS 656.325~~, to be deducted from future benefits.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, 656.254, 656.745

AMEND: 436-015-0120

RULE SUMMARY: Amended OAR 436-015-0120 –

- Has a revised reference to subsections of ORS 656.745, as renumbered by HB 2087 (2019); and
- Removes a statement about deposit of collected penalties to a department fund, because disposition of money paid is statutory.

CHANGES TO RULE:

436-015-0120
Sanctions and Civil Penalties ¶

(1) Complaints pertaining to violations of these rules must be sent to the director.¶
(2) The director may investigate an alleged rule violation. The investigation may include, but is not limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the complaint, or consultation with an appropriate panel of the medical provider's peers, chosen in the manner provided in OAR 436-010-0330.¶
(3) If the director finds any violation of OAR 436-015, or if the MCO fails to meet any of the requirements of the certified plan, the director may impose one or more of the following sanctions against an MCO:¶
(a) Reprimand by the director;¶
(b) Civil penalty as provided under ORS 656.745(2) ~~and (4). All penalties collected under this section must be paid into the Consumer and Business Services Fund~~. In determining the amount of penalty to be assessed, the director will consider:¶
(A) The degree of harm inflicted on the worker, insurer, or medical provider;¶
(B) Previous violations; and¶
(C) Evidence of willful violation~~.~~; or¶
(c) Suspension or revocation of the MCO's certification under OAR 436-015-0080.¶
(4) If the director determines that an insurer has entered into a contract with an MCO that violates OAR 436-015 or the MCO's certified plan, the insurer will be subject to civil penalties as provided in ORS 656.745.¶
(5) If an insurer or someone who is not a certified MCO acting on the insurer's behalf engages in managed care activities prohibited under these rules, the director may impose a sanction or civil penalty.
Statutory/Other Authority: ORS 656.~~7~~26~~(4)~~0, ORS 656.726~~0~~(4)
Statutes/Other Implemented: ORS 656.260, 656.745

AMEND: 436-055-0110

RULE SUMMARY: Amended OAR 436-055-0110 implements HB 2087 (2019), which raised the limits for certain civil penalty maximums; references to specific dollar amounts are replaced by a reference to ORS 656.745(2).

CHANGES TO RULE:

436-055-0110
Assessment of Civil Penalties ¶

(1) Penalties for failure to comply with statutes, rules, and orders. The director may assess a civil penalty under ORS 656.745(2) against an insurer that ~~fails to comply with these rules under ORS 656.745~~violates ORS chapter 656, OAR 436-055, or an order of the director.¶
(2) Penalties for failure to comply with ORS 656.780. The director may assess a civil penalty against an insurer that fails to maintain or produce certification and training records as required by these rules, or that employs anyone other than an Oregon certified claims examiner to process claims.¶
~~(3) Penalty amounts. No civil penalty will exceed $2,000 for each violation, or $10,000 in aggregate for all violations within a three-month period. Each violation, or each day a violation continues, will be considered a separate violation.~~
Statutory/Other Authority: ORS 656.726, ORS 656.780
Statutes/Other Implemented: ORS 656.7~~45,~~80, ORS 656.7~~80~~45

AMEND: 436-060-0025

RULE SUMMARY: Amended OAR 436-060-0025 implements HB 3146 (2019), by replacing “inmate” with “adult in custody.”

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 consent of the worker, the employer may pay the worker amounts in addition to the temporary disability benefits due the worker, if:¶
(a) The employer identifies temporary disability benefits separately from other payments; and¶
(b) The employer 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 that 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 that there is medical verification that 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-~~05~~18<u>0</u> 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, when calculating the average wages;¶
(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. 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 had been 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, as confirmed by the employer and the 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;¶
(c) Wages for other pay intervals must be calculated on an equivalent basis; or¶
(d) 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 January 1, 2018 must be calculated under this subsection.¶
(B) The rate of compensation for workers employed through a union hiring hall with dates of injury from January 1, 2017 through December 31, 2017 must be calculated under this subsection, unless such calculation would result in a reduction of benefits.¶
(6) Workers with no wages. If the worker is a volunteer, ~~inmate~~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) Wage disputes. If the worker disputes the wage used to calculate the rate of compensation, the insurer must attempt to resolve the dispute by contacting the employer to confirm the correct wage and then contacting the worker with that information. If the worker still 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, 656.726(4)
Statutes/Other Implemented: ORS 656.704, 656.210

AMEND: 436-060-0200

RULE SUMMARY: Amended OAR 436-060-0200 –
- States that the director “will assess” rather than “may assess” a civil penalty under ORS 656.745(1), to align the rule with the statute;
- Implements HB 2087 (2019), which raised the limits for certain civil penalty maximums; references to specific dollar amounts are replaced by references to ORS 656.745(2); and
- Includes minor wording changes that enhance clarity.

CHANGES TO RULE:

436-060-0200
Assessment of Civil Penalties ¶

(1) Penalties for inducing failure to report claims. The director ~~may~~will assess a civil penalty under ORS 656.745(1) against an employer or insurer that intentionally or repeatedly induces workers to fail to report accidental injuries, causes employees to collect accidental injury claims as off-the-job injury claims, persuades workers to accept less than the compensation due or makes it necessary for workers to resort to proceedings against the employer to secure compensation due.¶
(a) A penalty under this section will only be assessed after all litigation on the matter has become final by operation of the law.¶
(b) For the purpose of this section:¶
(A) "Intentionally" means the employer or insurer acted with a conscious objective to ~~cause any result described in ORS 656.745(1) or to~~ engage in the conduct or cause any result described in th~~at~~is section; and¶
(B) "Repeatedly" means more than once in any ~~twelve~~ 12-month period.¶
(2) Penalties for failure to comply with statutes, rules, and orders. The director may assess a civil penalty under ORS 656.745(2) against an employer or insurer that ~~does not comply with the rules and~~violates ORS chapter 656, OAR chapter 436, or orders of the director regarding reports or other requirements necessary to carry out the purposes of ORS chapter 656. Except as provided in ORS 656.780, the director may assess a civil penalty against a service company only for claims processing violations identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an employer, insurer, or service company identified in an annual audit.¶
(3) Penalties for failure to meet time frame requirements. The director may assess a civil penalty ~~of up to $2,000~~ under ORS 656.745(2) against an employer or insurer that does not meet the time frame requirements in OAR 436-060-0010, 436-060-0011, 436-060-0017, 436-060-0018, 436-060-0030, 436-060-0060, 436-060-0140, 436-060-0147, 436-060-0155 and 436-060-0180. The director may assess a civil penalty ~~of up to $2,000 to~~under ORS 656.745(2) against a service company ~~failing to~~that does not meet the time frame requirements, only for violations identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an employer, insurer, or service company identified in an annual audit.¶
(4) Penalties for use of sight draft to pay compensation. The director may assess a civil penalty ~~of up to $2,000~~ under ORS 656.745(2) against an insurer that willfully violates OAR 436-060-0160.¶
(5) Penalties for inaccurate reporting of first payment timeliness. The director may assess a civil penalty ~~of $500~~ under ORS 656.745(2) against an insurer that does not accurately report timeliness of first payment information to the division~~, plus $50 for each violation, up to $10,000 in the aggregate for all violations within any three month period~~. The director may assess this civil penalty against~~o~~ the service company processing the insurer's claims if the violations were identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an insurer or service company identified in an annual audit. For the purposes of this section, a violation consists of each situation in which a first payment was reported to have been made timely, but was found upon audit to have actually been late.¶
(6) Penalties for failure to comply with claims processing requirements. Notwithstanding section (3) of this rule,

the director may assess civil penalties ~~of up to $2,000~~under ORS 656.745(2) against an employer, insurer, or service company for each violation of the claims processing requirements of ORS chapter 656, OAR chapter 436 ~~and~~, or orders of the director.¶

~~(a) Penalties assessed for all violations will not exceed $10,000 in the aggregate within any three month period.¶~~

~~(b)~~ For the purpose of this section, the statutory claims processing requirements include but are not limited to, ORS 656.202, 656.210, 656.212, 656.228, 656.234, 656.236, 656.245, 656.262, 656.263, 656.264, 656.265, 656.268, 656.273, 656.307, 656.313, 656.325, and 656.331.¶

(7) Penalties for misrepresentation to obtain claims records. The director may assess a civil penalty of $1,000 against any employer or insurer that misrepresents itself in any manner to obtain workers' compensation claims records from the director, or that uses such records in a manner contrary to these rules. In addition, the director may suspend or revoke:¶

(a) An employer's or insurer's access to workers' compensation claims records for such time as the director may determine; or¶

(b) Any other person's access to workers' compensation claims records if the director determines they have misrepresented themselves or used records in a manner contrary to these rules.¶

(8) Performance audits. Insurers will be subject to periodic performance audits. Civil penalties may be issued for each area where the insurer's performance falls below the acceptable standards set forth in the rules and orders of the director.¶

(9) Considerations for assessing penalties. In arriving at the amount of penalty under this rule, the director may consider, but is not limited to:¶

(a) The ratio of the volume of violations to the volume of claims reported;¶

(b) The ratio of the volume of violations to the average volume of violations for all insurers; and¶

(c) Prior performance in meeting the requirements outlined in this section.¶

(10) Penalty to worker's attorney for failure to cooperate with insurer's investigation. The director may assess a civil penalty not to exceed $1,000 against a worker's attorney that is unreasonably unwilling or unavailable to participate in an insurer's interview as required by ORS 656.262(14).¶

~~[ED. NOTE: Appendices & Forms referenced are available from the agency.]~~

Statutory/Other Authority: ORS 656.704, ORS 656.726(4)

Statutes/Other Implemented: ORS 656.704, ORS 656.726(4), 656.202, 656.210, 656.212, 656.228, 656.234, 656.236, 656.245, 656.262, 656.263, 656.264, 656.265, 656.268, 656.273, 656.307, 656.313, 656.325, 656.331, ~~656.704, 656.726(4),~~ 656.745

AMEND: 436-070-0050

RULE SUMMARY: Amended OAR 436-070-0050 implements HB 2087 (2019), which raised the limits for certain civil penalty maximums; references to minimum and maximum dollar amounts are replaced by a reference to ORS 656.745(2).

CHANGES TO RULE:

436-070-0050
Assessment of Civil Penalties ¶

~~(1)~~ The director ~~pursuant to ORS 656.745~~ may assess a civil penalty ~~against an employer.¶~~
~~(2) If the director finds any employer in violation of OAR 436-070 or an order of the director, the employer may be subject to penalties pursuant to ORS 656.745 of not more than $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, will be considered a separ~~under ORS 656.745(2) against an employer th~~ate~~ violat~~ion.¶~~
~~(3) An employer may be assessed a penalty for late filing or payment when received more than 10 calendar days after the due date established in OAR 436-070-0020(2). The penalty will be assessed at 10% of the outstanding balance, with a minimum of $50 for each violation up to $2,000. Penalties are in addition to interest and assessments owed~~es ORS chapter 656, OAR 436-070, or an order of the director.
Statutory/Other Authority: ORS 656.74~~5(2~~26(4)
Statutes/Other Implemented: ORS 656.745

AMEND: 436-085-0060

RULE SUMMARY: Amended OAR 436-085-0060 implements HB 2087 (2019), which raised the limits for certain civil penalty maximums; references to specific dollar amounts are replaced by a reference to ORS 656.745(2).

CHANGES TO RULE:

436-085-0060
Assessment of Civil Penalties ¶

~~(1)~~ The director ~~pursuant to ORS 656.745~~ may assess a civil penalty ~~against an insurer, self-insured employer, or self-insured employer group.¶~~
~~(2) A~~under ORS 656.745(2) against an insurer, self-insured employer, or self-insured employer group ~~in~~that violat~~ion of OAR 436-085, may be assessed a civil penalty of up to $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period. Each violation or each day a violation continues, will be considered a separate violation~~es ORS chapter 656, OAR 436-085, or an order of the director.
Statutory/Other Authority: ORS ~~656.612, 656.614,~~ 656.726(4)
Statutes/Other Implemented: ORS ~~656.735, 656.740,~~ 656.745

AMEND: 436-110-0310

RULE SUMMARY: Amended OAR 436-110-0310 –
- Implements HB 3146 (2019), by replacing “inmate” with “adult in custody”; and
- Includes minor wording changes that enhance clarity.

CHANGES TO RULE:

436-110-0310
Eligibility and End of Eligibility for the Preferred Worker Program ¶

(1) Employer eligibility. The eligibility requirements for the Preferred Worker Program for an employer, including the employer at injury, except as provided in OAR 436-110-0345(1) for employment purchases, are:¶
(a) The employer has and maintains Oregon workers' compensation insurance coverage;¶
(b) The employer complies with the Oregon workers' compensation law;¶
(c) The employer must offer or provide employment to an eligible preferred worker who is a subject Oregon worker according to ORS 656.027;¶
(d) If the employer is a worker leasing company, it must be licensed with the director under ORS 656.850; and¶
(e) The employer is not currently ineligible for preferred worker benefits under OAR 436-110-0900.¶
(2) Worker eligibility. The eligibility requirements for a worker for the Preferred Worker Program are:¶
(a) The worker has an accepted disabling Oregon compensable injury or occupational disease. ~~Injuries to inmates covered~~Adults in custody eligible for benefits under ORS 655.505 to 655.555 and OAR 125-160 ~~do~~are not ~~qualify;~~eligible; ¶
(b) The worker will not be able to return to regular work, as indicated by medical evidence and due to injury-caused restrictions, under any claim opening;¶
(c) Medical documentation indicates permanent restrictions exist as a result of the injury or disease, whether or not an order has been issued awarding permanent disability;¶
(d) The worker is authorized to work in the United States; and¶
(e) The worker complies with the Oregon workers' compensation law.¶
(3) Work experience program participants, apprentices, and trainees.¶
(a) Individuals covered under ORS 656.033, 656.046, 656.135, or 656.138, are eligible for the Preferred Worker Program if they otherwise meet the eligibility requirements in section (2) of this rule.¶
(b) For purposes of the Preferred Worker Program, for individuals covered under ORS 656.033, 656.046, 656.135, or 656.138, the job for which the individual was being trained is considered regular work.¶
(4) Self-employment. A worker may not use preferred worker benefits for self-employment unless the injury that gave rise to the worker's eligibility for the Preferred Worker Program occurred in the course and scope of self-employment. In that case, the worker may use the benefits to return to the same self-employment or for employment other than self-employment.¶
(5) Ending eligibility. Reasons for ending Preferred Worker Program eligibility include, but are not limited to, the following:¶
(a) Misrepresentation or omission of information by a worker or employer to obtain assistance;¶
(b) Failure of a worker or employer to provide requested information or cooperate;¶
(c) Falsification or alteration of a preferred worker card or a Preferred Worker Program agreement;¶
(d) Conviction of fraud in obtaining workers' compensation benefits;¶
(e) The worker no longer meets the eligibility requirements under section (2) of this rule; or¶
(f) The employer no longer meets the eligibility requirements under section (1) of this rule.¶
(6) Reinstatement of eligibility. The director retains the right to reinstate Preferred Worker Program eligibility if eligibility was ended prematurely or in error, or if the employer has reinstated or obtained workers' compensation insurance coverage.¶
(7) Redetermination of eligibility. A worker found ineligible because the worker was not authorized to work in the United States may request a redetermination of eligibility after providing the division with documentation that

the worker is authorized to work in the United States.
Statutory/Other Authority: ORS 656.622, 656.726(4)
Statutes/Other Implemented: ORS 656.622

AMEND: 436-140-0120

RULE SUMMARY: Amended OAR 436-140-0120 –
- Implements HB 2087 (2019), which raised the limits for certain civil penalty maximums; references to specific dollar amounts are replaced by a reference to ORS 656.745(2); and
- Includes minor wording changes that enhance clarity.

CHANGES TO RULE:

436-140-0120
Sanctions and Civil Penalties; Rule Violations ¶

(1) ~~Pursuant to~~The director may assess a civil penalty under ORS 656.745 against an~~y~~ employer, group of employers, ~~and/~~or insurer ~~s~~that~~ll be subject to penalties if the director finds it in violation of~~t violates ORS chapter 656, OAR 436-140, or an order of the director. ~~The penalty shall not be more than $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, shall be considered a separate violation.~~¶
(2) Any complaint alleging a violation of these rules ~~shall~~must be made in writing to the director. The complaint must:¶
(a) State the grounds for the alleged rule violation;¶
(b) Include the specific instances of the alleged rule violation;¶
(c) State the complainant's request for correction and relief; and¶
(d) Include sufficient documentation to support the complaint.¶
~~(3) If the director determines upon investigation that a rule violation has occurred, the director may issue penalties pursuant to ORS 656.745 and this rule.~~
Statutory/Other Authority: ORS 656.726(4), 656.174
Statutes/Other Implemented: ORS 656.~~170, 656.172, 656.1~~745