Oregon
Kate Brown, Governor

Department of Consumer and Business Services
Workers' Compensation Division
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June 16, 2017

Proposed Changes to Workers' Compensation Rules

Amendments to reflect the Oregon Supreme Court's decision in *Brown v. SAIF Corporation*

The Workers' Compensation Division proposes changes to OAR:

- OAR 436-010, Medical Services
- OAR 436-030, Claim Closure and Reconsideration
- OAR 436-035, Disability Rating Standards

Please review the attached documents for more information about proposed changes and possible fiscal impacts.

The department welcomes public comment on proposed changes and has scheduled a public hearing.

When is the hearing? July 25, 2017, 9 a.m.

Where is the hearing?
Labor & Industries Building
350 Winter Street NE, Room F (basement)
Salem, Oregon 97301

How can I make a comment?
Come to the hearing and speak, send written comments, or do both. Send written comments to:
Email – fred.h.bruyns@oregon.gov
Fred Bruyns, rules coordinator
Workers' Compensation Division
350 Winter Street NE (for courier or in-person delivery)
PO Box 14480, Salem, OR 97309-0405
Fax – 503-947-7514

The closing date for written comments is July 31, 2017.

How can I get copies of the proposed rules and view testimony?

On the Workers' Compensation Division's website –

http://wcd.oregon.gov/laws/Pages/proposed-rules.aspx.

Or call 503-947-7717 to get free paper copies

Questions? Contact Fred Bruyns, 503-947-7717.

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Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form

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6-15-17 1:16 PM
ARCHIVES DIVISION
SECRETARY OF STATE

Department of Consumer and Business Services, Workers' Compensation Division — 436
Agency and Division — Administrative Rules Chapter Number

Fred Bruyns — (503) 947-7717
Rules Coordinator — Telephone

Department of Consumer and Business Services, Workers' Compensation Division, PO Box 14480, Salem, OR 97309-0405
Address

RULE CAPTION

Amendments to reflect the Oregon Supreme Court's decision in Brown v. SAIF Corporation

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

Hearing Date	Time	Location	Hearings Officer
7-25-17	9:00 a.m.	Room F Labor & Industries Building, 350 Winter St. NE, Salem	Fred Bruyns

RULEMAKING ACTION

Secure approval of rule numbers with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND:
436-010-0280, 436-010-0290, 436-030-0020, 436-030-0035, 436-035-0006, 436-035-0013

REPEAL:

RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

AMEND AND RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

Statutory Authority:
ORS 656.268, 656.726(4)

Other Authority:

Statutes Implemented:
ORS 656.214, 656.252, 656.268

RULE SUMMARY

The public may also listen to the hearing or testify by telephone:
Dial-in number is 1-213-787-0529; Access code is 9221262#.

The agency proposes to amend OAR chapter 436 to:

- Reflect changes in interpretation of workers' compensation statutes by the Oregon Supreme Court in Brown v. SAIF Corporation, 361 Or 241 (2017), primarily the court's determination that "otherwise compensable injury" in ORS 656.005(7)(a)(B), refers to a medical condition and not to an injury incident;
- Eliminate references to a "condition directly resulting from the work injury";
- Update the examples in OAR 436-035-0013;
- Replace a reference to "compensable condition" with "accepted condition(s)"; and
- Replace some references to "injury claims" to indicate "initial injury claims", as well as some references to "injury claim" to indicate "initial injury claim".

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.

07-31-2017 Close of Business	Fred Bruyns	fred.h.bruyns@oregon.gov
Last Day *(m/d/yyyy)* and Time for public comment	Rules Coordinator Name	Email Address

*The Oregon Bulletin is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation.

Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing accompanies this form.

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ARCHIVES DIVISION
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Department of Consumer and Business Services, Workers' Compensation Division — 436
Agency and Division — Administrative Rules Chapter Number

Amendments to reflect the Oregon Supreme Court's decision in Brown v. SAIF Corporation

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of:

Amendment of:

OAR 436-010, Medical Services
OAR 436-030, Claim Closure and Reconsideration
OAR 436-035, Disability Rating Standards

Statutory Authority:
ORS 656.268, 656.726(4)

Other Authority:

Statutes Implemented:
ORS 656.214, 656.252, 656.268

Need for the Rule(s):

Temporary rules were issued, effective April 11, 2017, to align OAR chapter 436 with ORS chapter 656 as interpreted by the Oregon Supreme Court in Brown v. SAIF Corporation, 361 Or 241 (2017). Permanent rules are needed to replace the temporary rules before they expire, to provide needed guidance for parties, and to explain how the division will carry out its responsibilities.

Documents Relied Upon, and where they are available:

The decision of the Oregon Supreme Court in Brown v. SAIF Corporation, 361 Or 241 (2017), advisory committee meeting records, and 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:

The agency projects that proposed rule changes will have little or no fiscal impact on the agency. Possible economic effects, if any, on other state agencies, units of local government, and the public are described below under "Statement of Cost of Compliance."

Statement of Cost of Compliance:

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 have no direct impact on costs of state agencies.

b. The agency estimates that there will be no direct impact on units of local government except for self-insured cities and counties and other government entities that are self-insured. See the impacts under the "public" below.

c. The agency estimates that proposed rule changes will have some effect on costs to the public, largely by reversing any effects of rulemaking completed in 2015 to reflect the Oregon Court of Appeals decision in Brown v. SAIF (262 Or. App. 640 (2014)). For those rule changes, which also included revisions in response to Schleiss v. SAIF (364 Or. 637 (2013)), the agency estimated a range of possible impacts on workers' compensation premiums of from $4.24 million to $26.49 million. Experience suggests these cost estimates may have been too high. While many factors affect claims costs, pure premium rates for 2016 and 2017 dropped by 5.3 percent and 6.6 percent respectively. The agency does not have sufficient data to determine the impact of prior rulemaking to reflect the Court of Appeals decision or with which to project an impact of rulemaking to reflect the Supreme Court decision. However, proposed rule changes should largely reverse any Brown v. SAIF-related impacts of the 2015 changes. While the 2015 changes in response to the Court of Appeal's Brown decision increased insurers' costs for those claims affected by that decision, and provided a corresponding increase in benefits to affected workers, the 2017 changes reverse this impact and therefore lower insurers' costs for claims affected by the Supreme Court's decision, while producing a corresponding decrease in benefits to affected workers.

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

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

Proposed rule changes may put some downward pressure on workers' compensation premium costs. Any reduction in premium should benefit businesses, large and small. Oregon has approximately 112,000 employers. At least 90 percent of employers are small businesses as defined

in ORS 183.310.

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

The agency projects that there will not be significant increases or decreases in costs for reporting, recordkeeping, administrative activities, or professional services.

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

The agency projects that there will not be significant increases or decreases in costs for equipment, supplies, labor, or increased administration.

How were small businesses involved in the development of this rule?

The agency notified more than 3,000 stakeholders, including many who represent the interests of small businesses, of an advisory committee meeting and invited attendance. Several of the committee attendees were owners or employees of small businesses.

Administrative Rule Advisory Committee consulted?: Yes
If not, why?:

07-31-2017 Close of Business	Fred Bruyns	fred.h.bruyns@oregon.gov
Last Day (m/d/yyyy) and Time for public comment	Printed Name	Email Address

Medical Services
Oregon Administrative Rules
Chapter 436, Division 010

Proposed

436-010-0280 Determination of Impairment / Closing Exams

(1) When a worker has received compensation for time loss or it is likely the worker has permanent impairment and becomes medically stationary, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. If the worker is under the care of an authorized nurse practitioner or a type B attending physician, other than a chiropractic physician, the provider must refer the worker to a type A attending physician to do a closing exam.

(2) The closing exam must be completed under OAR 436-030 and 436-035 and Bulletin 239. (See Appendix A "Matrix for Health Care Provider Types".)

(3) When the attending physician completes the closing exam, the attending physician has 14 days from the medically stationary date to send the closing report to the insurer. When the attending physician does not complete the closing exam, the attending physician must arrange, or ask the insurer to arrange, a closing exam with a consulting physician within seven days of the medically stationary date.

(4) When an attending physician or authorized nurse practitioner requests a consulting physician to do the closing exam, the consulting physician has seven days from the date of the exam to send the report to the attending physician for concurrence or objections. Within seven days of receiving the closing exam report, the attending physician must state in writing whether the physician concurs with or objects to all or part of the findings of the exam, and send the concurrence or objections with the report to the insurer.

(5) The attending physician must specify the worker's residual functional capacity if:

(a) The attending physician has not released the worker to the job held at the time of injury because of a permanent work restriction caused by the compensable injury, and

(b) The worker has not returned to the job held at the time of injury, because of a permanent work restriction caused by the compensable injury.

(6) Instead of specifying the worker's residual functional capacity under section (5) of this rule, the attending physician may refer the worker for:

(a) A second-level physical capacities evaluation (see OAR 436-009-0060) when the worker has not been released to return to the job held at the time of injury, has not returned to the job held at the time of injury, has returned to modified work, or has refused an offer of modified work; or

(b) A work capacities evaluation (see OAR 436-009-0060) when there is a question of the worker's ability to return to suitable and gainful employment. The provider may also be required to specify the worker's ability to perform specific job tasks.

(7) When the insurer issues a major contributing cause denial on an accepted claim and the worker is not medically stationary:

(a) The attending physician must do a closing exam or refer the worker to a consulting physician for all or part of the closing exam; or

(b) An authorized nurse practitioner or a type B attending physician, other than a chiropractic physician, must refer the worker to a type A attending physician for a closing exam.

(8) The closing report must include all of the following:

(a) Findings of permanent impairment.

(A) In an initial injury claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted condition~~,~~ or a direct medical sequela of an accepted condition~~, or a condition directly resulting from the work injury~~.

(B) In a new or omitted condition claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(C) In an aggravation claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(D) In an occupational disease claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(b) Findings documenting permanent work restrictions.

(A) If the worker has no permanent work restriction, the closing report must include a statement indicating that:

(i) The worker has no permanent work restriction; or

(ii) The worker is released, without restriction, to the job held at the time of injury.

(B) In an initial injury claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted condition~~,~~ or a direct medical sequela of an accepted condition~~, or a condition directly resulting from the work injury~~.

(C) In a new or omitted condition claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(D) In an aggravation claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(E) In an occupational disease claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted occupational disease or a direct medical sequel of an accepted occupational disease.

(c) A statement regarding the validity of an impairment finding is required in the following circumstances:

(A) If the examining physician determines that a finding of impairment is invalid, the closing report must include a statement that identifies the basis for the determination that the finding is invalid.

(B) If the examining physician determines that a finding of impairment is valid but the finding is not addressed by any applicable validity criteria under Bulletin 239, the closing report must include a statement that identifies the basis for the determination that the finding is valid.

(C) If the examining physician chooses to disregard applicable validity criteria under Bulletin 239 because the criteria are medically inappropriate for the worker, the closing report must include a statement that describes why the criteria would be inappropriate.

Stat. Auth: ORS 656.726(4), 656.245(2)(b)
Stats. Implemented: ORS 656.245, 656.252
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
Amended 4/10/17 as Admin. Order 17-052, eff. 4/11/17 (temp)
Amended xx/xx/xx as Admin. Order 17-XXX, eff. xx/xx/xx
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0290 Medical Care After Medically Stationary

(1) A worker is found medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. Medical services after a worker's condition is medically stationary are compensable only when services are:

(a) Palliative care under section (2) of this rule;

(b) Curative care under sections (3) and (4) of this rule;

(c) Provided to a worker who has been determined permanently and totally disabled;

(d) Prescription medications;

(e) Necessary to administer or monitor administration of prescription medications;

(f) Prosthetic devices, braces, or supports;

(g) To monitor the status of, to replace, or to repair prosthetic devices, braces, and supports;

(h) Provided under an accepted claim for aggravation;

(i) Provided under Board's Own Motion;

(j) Necessary to diagnose the worker's condition; or

(k) Life-preserving modalities similar to insulin therapy, dialysis, and transfusions.

(2) Palliative Care.

(a) Palliative care means that medical services are provided to temporarily reduce or moderate the intensity of an otherwise stable medical condition. It does not include those medical services provided to diagnose, heal, or permanently alleviate or eliminate a medical condition. Palliative care is compensable when the attending physician prescribes it and it is necessary to enable the worker to continue current employment or a vocational training program. Before palliative care can begin, the attending physician must submit a written palliative care request to the insurer for approval. The request must:

(A) Describe any objective findings;

(B) Identify the medical condition for which palliative care is requested by the appropriate ICD diagnosis;

(C) Detail a treatment plan which includes the name of the provider who will provide the care, specific treatment modalities, and frequency and duration of the care, not to exceed 180 days;

(D) Explain how the requested care is related to the ~~compensable condition~~accepted condition(s); and

(E) Describe how the requested care will enable the worker to continue current employment, or a current vocational training program, and the possible adverse effect if the care is not approved.

(b) Palliative care may begin after the attending physician submits the request to the insurer. If the insurer approves the request, palliative care services are payable from the date service begins. However, if the request is ultimately disapproved, the insurer is not liable for payment of the palliative care services.

(c) Insurers must date stamp all palliative care requests upon receipt. Within 30 days of receiving the request, the insurer must send written notice to the attending physician, worker, and worker's attorney approving or disapproving the request.

(d) If the insurer disapproves the request, the insurer must explain the reason why in writing. Reasons to disapprove a palliative care request may include:

(A) The palliative care services are not related to the accepted condition(s);

(B) The palliative care services are excessive, inappropriate, or ineffectual; or

(C) The palliative care services will not enable the worker to continue current employment or a current vocational training program.

(e) When the insurer disapproves the palliative care request, the attending physician or the worker may request administrative review before the director under OAR 436-010-0008. The request for review must be within 90 days from the date of the insurer's disapproval notice. In addition to information required by OAR 436-010-0008, if the request is from the attending physician, it must include:

(A) A copy of the original request to the insurer; and

(B) A copy of the insurer's response.

(f) If the insurer fails to respond to the request in writing within 30 days, the attending physician or worker may request approval from the director within 120 days from the date the request was first submitted to the insurer. When the attending physician requests approval from the director, the physician must include a copy of the original request and may include any other supporting information.

(g) Subsequent requests for palliative care are subject to the same process as the initial request; however, the insurer may waive the requirement that the attending physician submit a supplemental palliative care request.

(3) Curative Care.

Curative medical care is compensable when the care is provided to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition.

(4) Advances in Medical Science.

The director must approve curative care arising from a generally recognized, nonexperimental advance in medical science since the worker's claim was closed that is highly likely to improve the worker's condition and that is otherwise justified by the circumstances of the claim. When the attending physician believes that curative care is appropriate, the physician must submit a written request for approval to the director. The request must:

(a) Describe any objective findings;

(b) Identify the appropriate ICD diagnosis (the medical condition for which the care is requested);

(c) Describe in detail the advance in medical science that has occurred since the worker's

claim was closed that is highly likely to improve the worker's condition;

(d) Provide an explanation, based on sound medical principles, as to how and why the care will improve the worker's condition; and

(e) Describe why the care is otherwise justified by the circumstances of the claim.

Stat. Auth: ORS 656.726
Stats. Implemented: ORS 656.245
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
Amended xx/xx/xx as Admin. Order 17-XXX, eff. xx/xx/xx
See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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

Proposed

436-030-0020 Requirements for Claim Closure

(1) **Issuance of a Notice of Closure.** Unless the worker is enrolled and actively engaged in training, the insurer must issue a Notice of Closure on an accepted disabling claim within 14 days when:

(a) Medical information establishes that there is sufficient information to determine the extent of permanent disability and indicates that the worker is medically stationary;

(b) The compensable injury is no longer the major contributing cause of the worker's combined or consequential condition(s), a major contributing cause denial has been issued, and there is sufficient information to determine the extent of permanent disability;

(c) The worker fails to seek medical treatment for 30 days for reasons within the worker's control and the worker has been notified of pending actions in accordance with these rules;

(d) The worker fails to attend a mandatory closing examination for reasons within the worker's control and the worker has been notified of pending actions in accordance with these rules; or

(e) A worker receiving permanent total disability benefits has materially improved and is capable of regularly performing work at a gainful and suitable occupation.

(2) **Sufficient Information.** For purposes of determining the extent of permanent disability, except as provided in section (14) of this rule for closure after training, "sufficient information" requires: a qualifying statement of no permanent disability under subsection (a) of this section or a qualifying closing report under subsection (b) of this section. Additional documentation is required under subsection (c) of this section unless there is clear and convincing evidence that an attending physician or authorized nurse practitioner has released the worker to the job held at the time of injury or that the worker has returned to the job held at the time of injury.

(a) **Qualifying statements of no permanent disability.** A statement indicating that there is no permanent disability is sufficient if it meets all of the following requirements:

(A) **Qualified providers.** An authorized nurse practitioner or attending physician must provide or concur with the statement.

(B) **Support by the medical record.** The statement must be supported by the medical record. If the medical record reveals otherwise, a closing examination and report specified under subsection (b) of this section are required.

(C) **In initial injury claims.** In an initial injury claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment caused in any part by an accepted condition~~,~~ or a direct medical sequela of an accepted condition~~, or a condition directly resulting from the work injury~~; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted condition~~,~~ or a direct medical sequela of an accepted condition~~, or a condition directly resulting from the work injury~~.

(D) **In new or omitted condition claims.** In a new or omitted condition claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(E) **In aggravation claims.** In an aggravation claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(F) **In occupational disease claims.** In an occupational disease claim, the statement must clearly indicate the following:

(i) There is no reasonable expectation of any permanent impairment caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease; and

(ii) There is no reasonable expectation of any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(b) **Qualifying closing reports.** A closing medical examination and report are required if there is a reasonable expectation of permanent disability. A closing report is sufficient if it meets all of the following requirements:

(A) **Qualified providers.** A type A attending physician or a chiropractic physician serving as the attending physician must provide or concur with the closing report.

(B) **Release to regular work.** If the worker has no permanent work restriction, the closing report must include a statement indicating that:

(i) The worker has no permanent work restriction; or

(ii) The worker is released, without restriction, to the job held at the time of injury.

(C) **In initial injury claims.** In an initial injury claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment caused in any part by an accepted condition~~,~~ or a direct medical sequela of an accepted condition~~, or a condition directly resulting from the work injury~~; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted condition~~,~~ or a direct medical sequela of an accepted condition~~, or a condition directly resulting from the work injury~~.

(D) **In new or omitted condition claims.** In a new or omitted condition claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(E) **In aggravation claims.** In an aggravation claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(F) **In occupational disease claims.** In an occupational disease claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:

(i) Any permanent impairment caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease; and

(ii) Any permanent work restriction that:

(I) Prevents the worker from returning to the job held at the time of injury; and

(II) Is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(c) **Additional documentation.** Unless there is clear and convincing evidence that an attending physician or authorized nurse practitioner has released the worker to the job held at the time of injury (for dates of injury on or after January 1, 2006) or that the worker has returned to the job held at the time of injury, all of the following is required:

(A) An accurate description of the physical requirements of the worker's job held at the time of injury, which has been provided by certified mail to the worker and the worker's legal representative, if any, either before closing the claim or at the time the claim is closed;

(B) The worker's wage established consistent with OAR 436-060;

(C) The worker's date of birth;

(D) Except as provided in OAR 436-030-0015(4)(d), the worker's work history for the period beginning five years before the date of injury to the mailing date of the Notice of Closure, including tasks performed or level of SVP, and physical demands; and

(E) The worker's level of formal education.

(3) When determining disability and issuing the Notice of Closure, the insurer must apply all statutes and rules consistent with their provisions, particularly as they relate to major contributing cause denials, worker's failure to seek treatment, worker's failure to attend a mandatory examination, medically stationary status, temporary disability, permanent partial and total disability, review of permanent partial and total disability.

(4) When issuing a Notice of Closure, the insurer must prepare and attach a summary worksheet, "Notice of Closure Worksheet," Form 2807, as described by bulletin of the director.

(5) The "Notice of Closure," Form 1644, is effective the date it is mailed to the worker and to the worker's attorney if the worker is represented, or to the worker's estate if the worker is deceased, regardless of the date on the Notice itself.

(6) The notice must be in the form and format prescribed by the director in these rules and include only the following:

(a) The worker's name, address, and claim identification information;

(b) The appropriate dollar value of any individual scheduled or unscheduled permanent disability based on the value per degree for injuries occurring before January 1, 2005 or, for injuries occurring on or after January 1, 2005, the appropriate dollar value of any "whole person" permanent disability, including impairment and work disability as determined appropriate under OAR 436-035;

(c) The body part(s) awarded disability, coded to the table of body part codes as prescribed by the director;

(d) The percentage of loss of the specific body part(s), including either the number of degrees that loss represents as appropriate for injuries occurring before January 1, 2005, or the percentage of the whole person the worker's loss represents as appropriate for injuries occurring on or after January 1, 2005;

(e) If there is no permanent disability award for this Notice of Closure, a statement to that effect;

(f) The duration of temporary total and temporary partial disability compensation;

(g) The date the Notice of Closure was mailed;

(h) The medically stationary date or the date the claim statutorily qualifies for closure under OAR 436-030-0035 or 436-030-0034;

(i) The date the worker's aggravation rights end;

(j) The appeal rights of the worker and any beneficiaries;

(k) A statement that the worker has the right to consult with the Ombudsman for Injured Workers;

(l) For claims with dates of injury before January 1, 2005, the rate in dollars per degree at which permanent disability, if any, will be paid based on date of injury as identified in Bulletin 111;

(m) For claims with dates of injury on or after January 1, 2005, the state's average weekly wage applicable to the worker's date of injury;

(n) The worker's return to work status;

(o) A general statement that the insurer has the authority to recover an overpayment;

(p) A statement that the worker has the right to be represented by an attorney; and

(q) A statement that the worker has the right to request a vocational eligibility evaluation under ORS 656.340.

(7) The Notice of Closure (Form 1644) must be accompanied by the following:

(a) The brochure "Understanding Claim Closure and Your Rights";

(b) A copy of summary worksheet Form 2807 containing information and findings which result in the data appearing on the Notice of Closure;

(c) An accurate description of the physical requirements of the worker's job held at the time of injury unless it is not required under section (2)(a) of this rule or it was previously provided under section (2)(b)(A) of this rule;

(d) The Updated Notice of Acceptance at Closure which clearly identifies all accepted conditions in the claim and specifies those which have been denied and are on appeal or which were the basis for this opening of the claim; and

(e) A cover letter that:

(A) Specifically explains why the claim has been closed (e.g., expiration of a period of suspension without the worker resolving the problems identified, an attending physician stating the worker is medically stationary, worker failure to treat without attending physician authorization or establishing good cause for not treating, etc.);

(B) Lists and describes enclosed documents; and

(C) Notifies the worker about the end of temporary disability benefits, if any, and the anticipated start of permanent disability benefits, if any.

(8) A copy of the Notice of Closure must be mailed to each of the following persons at the same time, with each copy clearly identifying the intended recipient:

(a) The worker;

(b) The employer;

(c) The director; and

(d) The worker's attorney, if the worker is represented.

(9) If the worker is deceased at the time the Notice of Closure is issued:

(a) The worker's copy of the notice must be addressed to the estate of the worker and mailed to the worker's last known address.

(b) Copies of the notice may be mailed to any known or potential beneficiaries to the worker's estate. If a copy of the notice is mailed to a beneficiary, it must be mailed by both regular mail and certified mail return receipt requested.

(10) The worker's copy of the Notice of Closure must be mailed by both regular mail and certified mail return receipt requested.

(11) An insurer may use electronically produced Notice of Closure forms if consistent with the form and format prescribed by the director.

(12) Insurers may allow adjustments of benefits awarded to the worker under the documentation requirements of OAR 436-060-0170 for the following purposes:

(a) To recover payments for permanent disability which were made prematurely;

(b) To recover overpayments for temporary disability; and

(c) To recover overpayments for other than temporary disability such as prepaid travel expenses where travel was not completed, prescription reimbursements, or other benefits payable under ORS 656.001 to 656.794.

(13) The insurer may allow overpayments made on a claim with the same insurer to be deducted from compensation to which the worker is entitled but has not yet been paid.

(14) Under ORS 656.268(10), if, after claim closure, the worker becomes enrolled and actively engaged in an approved training program under OAR 436-120, the insurer must again close the claim consistent with the following:

(a) The claim must be closed when the worker ceases to be enrolled and actively engaged in the training and:

(A) The worker is medically stationary;

(B) The worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions; or

(C) The claim otherwise qualifies for closure under OAR 436-030-0034.

(b) If the worker is medically stationary, there must be a current (within three months before closure) determination of medically stationary status.

(c) For claims with dates of injury on or after January 1, 2005, permanent disability must be redetermined for work disability only. For claims with dates of injury before January 1, 2005, permanent disability must be redetermined for unscheduled disability only.

(d) Except for claims closed under ORS 656.268(1)(c), the insurer must have sufficient information to redetermine work disability or unscheduled disability. The requirements in section (2) of this rule regarding sufficient information apply only as necessary for the redetermination, as follows:

(A) For claims with dates of injury on or after January 1, 2005, the insurer must have sufficient information to determine work disability under OAR 436-035-0012. An evaluation of the adaptability factor of work disability under OAR 436-035-0012(7) through (13) must be based on a current (within three months before closure) medical determination of the worker's residual functional capacity.

(B) For claims with dates of injury before January 1, 2005, the insurer must have sufficient information to determine unscheduled disability under OAR 436-035-0008(2). An evaluation of unscheduled disability must be based on a current (within three months before closure) medical determination.

(15) When, after a claim is closed, the insurer changes or is ordered to change the worker's weekly wage upon which calculation of the work disability portion of a permanent disability award may be based, the insurer must notify the parties and the division of the change and the effect of the change on any permanent disability award. For purposes of this rule, the insurer must complete Form 1502 consistent with the instructions of the director and distribute it within 14 days of the change.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.210, 656.212, 656.214, 656.268 (2015 Or Laws, Ch. 144), 656.726, 656.745
Hist: Amended 5/21/15 as Admin. Order 15-059, eff. 5/21/15 (Temp)
Amended 10/12/15 as Admin. Order 15-061, eff. 11/17/15
Amended 4/10/17 as WCD Admin. Order 17-053, eff. 4/11/17 (temp)
Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. xx/xx/xx
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-030-0035 Determining Medically Stationary Status

(1) A worker is medically stationary in the following circumstances:

(a) **In initial injury claims.** In an initial injury claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted conditions~~,~~ and direct medical sequelae of accepted conditions~~, and conditions directly resulting from the work injury~~ are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(b) **In new or omitted condition claims.** In a new or omitted condition claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted new or omitted conditions and direct medical sequela of accepted new or omitted conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(c) **In aggravation claims.** In an aggravation claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted worsened conditions and direct medical sequela of accepted worsened conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(d) **In occupational disease claims.** In an occupational disease claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted occupational diseases and direct medical sequela of accepted occupational diseases are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.

(2) When there is a conflict in the medical opinions as to whether a worker is medically stationary, more weight is given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and clear and concise reasoning.

(3) Where there is not a preponderance of medical opinion stating a worker is or is not medically stationary, deference will generally be given to the opinion of the attending

physician. However, in cases where expert analysis is important, deference is given to the opinion of the physician with the greatest expertise in, and understanding of, the worker's medical condition.

(4) When there is a conflict as to the date upon which a worker became medically stationary, the following conditions govern the determination of the medically stationary date. The date a worker is medically stationary is the earliest date that a preponderance is established under sections (1) and (2) of this rule. The date of the examination, not the date of the report, controls the medically stationary date.

(5) The insurer must request the attending physician, as defined in ORS 656.005(12)(b)(A), to concur or comment when the attending physician arranges or refers the worker for a closing examination with another physician to determine the extent of impairment or when the insurer refers a worker for an independent medical examination. A concurrence with another physician's report is an agreement in every particular, including the medically stationary impression and date, unless the physician expressly states to the contrary and explains the reasons for disagreement. Concurrence cannot be presumed in the absence of the attending physician's response.

(6) A worker is medically stationary on the date of the examination when so specified by a physician. When a specific date is not indicated, a worker is presumed medically stationary on the date of the last examination, prior to the date of the medically stationary opinion. Physician projected medically stationary dates cannot be used to establish a medically stationary date.

(7) If the worker is incarcerated or confined in some other manner and unable to freely seek medical treatment, the insurer must arrange for medical examinations to be completed at the facility where the worker is located or at some other location accessible to the worker.

(8) If a worker dies and the attending physician has not established a medically stationary date, for purposes of claim closure, the medically stationary date is the date of death.

Statutory authority: ORS 656.268, ORS 656.726
Statutes implemented: ORS 656.268
Hist: Amended 11/1/07 as WCD Admin. Order 07-059, eff. 1/2/08
Amended 1/29/15 as Admin. Order 15-052, eff. 3/1/15
Amended 4/10/17 as WCD Admin. Order 17-053, eff. 4/11/17 (temp)
Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. xx/xx/xx
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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Disability Rating Standards
Oregon Administrative Rules
Chapter 436, Division 035

Proposed

436-035-0006 Determination of Benefits for Disability Caused by the Compensable Injury

(1) **In initial injury claims.** In an initial injury claim, permanent disability caused by the compensable injury includes disability caused by:

(a) An accepted condition; or

(b) A direct medical sequela of an accepted condition~~; or~~

~~(c) A condition directly resulting from the work injury, except that disability caused by a consequential condition under ORS 656.005(7)(a)(A), a combined condition under 656.005(7)(a)(B), or a preexisting condition under 656.225 is only awarded if the consequential, combined, or preexisting condition is accepted~~.

(2) **In new or omitted condition claims.** In a new or omitted condition claim, permanent disability caused by the compensable injury includes disability caused by:

(a) An accepted new or omitted condition; or

(b) A direct medical sequela of an accepted new or omitted condition.

(3) **In aggravation claims.** In an aggravation claim, permanent disability caused by the compensable injury includes disability caused by:

(a) An accepted worsened condition; or

(b) A direct medical sequela of an accepted worsened condition.

(4) **In occupational disease claims.** In an occupational disease claim, permanent disability caused by the compensable injury includes disability caused by:

(a) An accepted occupational disease; or

(b) A direct medical sequela of an accepted occupational disease.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.005, 656.214, 656.225, 656.268, 656.726, 656.802
Hist: Adopted 1/29/15 as WCD Admin. Order 15-053, eff. 3/1/15
Amended 4/10/17 as Admin. Order 17-054, eff. 4/11/17 (temp)
Amended xx/xx/xx as Admin. Order 17-XXX, eff. xx/xx/xx

436-035-0013 Findings of Impairment

(1) **Findings of impairment, generally.** Findings of impairment are objective medical findings that measure the extent to which a worker has suffered permanent loss of use or function of a body part or system.

(2) **Findings of impairment when the worker is medically stationary.** If the worker is medically stationary, findings of impairment are determined by performing the following steps:

(a) **In initial injury claims**.

(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted condition~~,~~ or a direct medical sequela of an accepted condition~~, or a condition directly resulting from the work injury~~.

(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and

(C) Establish the portion of the loss caused by:

(i) Any accepted condition;

(ii) Any direct medical sequela of an accepted condition;

(iii) ~~Any condition directly resulting from the work injury;~~

~~(iv)~~ Any condition that existed before the initial injury incident but does not qualify as a pre-existing condition;

(iv) Any pre-existing condition that is not otherwise compensable;

(v~~i~~) Any denied condition; and

(vi~~i~~) Any superimposed condition.

Example: **Accepted condition: Low back strain**

Superimposed condition: pregnancy (mid-term)

Denied condition: lumbar disc herniation

In the closing examination, the attending physician describes range of motion findings and states that 10% of the range of motion loss is due to the accepted condition, 50% of the loss is due to a lumbar disc herniation ~~that the attending physician determines directly results from the work injury~~, and 40% of the loss is due to the pregnancy. The worker is eligible for an impairment award for the ~~6~~10% of the range of motion loss that is due to the low back strain ~~and disc herniation~~. Under these rules, the range of motion loss is valued at 10%. 10% x .~~6~~10 equals 1~~6~~% impairment.

(b) **In new or omitted condition claims.**

(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and

(C) Establish the portion of the loss caused by:

(i) Any accepted new or omitted condition;

(ii) Any direct medical sequela of an accepted new or omitted condition;

(iii) In a new condition claim, any condition that existed before the onset of the accepted new medical condition but does not qualify as a pre-existing condition;

(iv) In an omitted condition claim, any condition that existed before the initial injury incident but does not qualify as a pre-existing condition;

(v) Any pre-existing condition that is not otherwise compensable;

(vi) Any denied condition; and

(vii) Any superimposed condition.

(c) **In aggravation claims.**

(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and

(C) Establish the portion of the loss caused by:

(i) Any accepted worsened condition;

(ii) Any direct medical sequela of an accepted worsened condition;

(iii) Any condition that existed before the onset of the accepted worsened condition but does not qualify as a pre-existing condition;

(iv) Any pre-existing condition that is not otherwise compensable;

(v) Any denied condition; and

(vi) Any superimposed condition.

(d) **In occupational disease claims.**

(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and

(C) Establish the portion of the loss caused by:

(i) Any accepted occupational disease;

(ii) Any direct medical sequela of an accepted occupational disease;

(iii) Any pre-existing condition that is not otherwise compensable;

(iv) Any denied condition; and

(v) Any superimposed condition.

(3) **Findings of impairment when the worker is not medically stationary.** Except for a claim closed under ORS 656.268(1)(c), if the worker is not medically stationary, findings of impairment are determined by performing the following steps:

(a) **In initial injury claims.**

(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted condition~~,~~ or a direct medical sequela of an accepted condition~~, or a condition directly resulting from the work injury~~ at the time the worker is likely to become medically stationary;

(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and

(C) Estimate the portion of the loss that is likely to be caused by:

(i) Any accepted condition;

(ii) Any direct medical sequela of an accepted condition;

(iii) ~~Any condition directly resulting from the work injury;~~

~~(iv)~~ Any condition that existed before the initial injury incident but does not qualify as a pre-existing condition;

(iv) Any pre-existing condition that is not otherwise compensable;

(v~~i~~) Any denied condition; and

(vi~~i~~) Any superimposed condition.

(b) **In new or omitted condition claims.**

(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition at the time the worker is likely to become medically stationary;

(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and

(C) Estimate the portion of the loss that is likely to be caused by:

(i) Any accepted new or omitted condition;

(ii) Any direct medical sequela of an accepted new or omitted condition;

(iii) In a new condition claim, any condition that existed before the onset of the accepted new medical condition but does not qualify as a pre-existing condition;

(iv) In an omitted condition claim, any condition that existed before the initial injury incident but does not qualify as a pre-existing condition;

(v) Any pre-existing condition that is not otherwise compensable;

(vi) Any denied condition; and

(vii) Any superimposed condition.

(c) **In aggravation claims.**

(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted worsened condition or a direct medical sequela of an accepted worsened condition at the time the worker is likely to become medically stationary;

(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and

(C) Estimate the portion of the loss that is likely to be caused by:

(i) Any accepted worsened condition;

(ii) Any direct medical sequela of an accepted worsened condition;

(iii) Any condition that existed before the onset of the accepted worsened condition but does not qualify as a pre-existing condition;

(iv) Any pre-existing condition that is not otherwise compensable;

(v) Any denied condition; and

(vi) Any superimposed condition.

(d) **In occupational disease claims.**

(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted occupational disease or a direct medical sequela of an accepted occupational disease at the time the worker is likely to become medically stationary;

(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and

(C) Estimate the portion of the loss that is likely to be caused by:

(i) Any accepted occupational disease;

(ii) Any direct medical sequela of an accepted occupational disease;

(iii) Any pre-existing condition that is not otherwise compensable;

(iv) Any denied condition; and

(v) Any superimposed condition.

(4) **Age and education.** The social-vocational factors of age and education (including SVP) are not apportioned, but are determined as of the date of issuance.

(5) **Irreversible findings of impairment or surgical value.** Workers with an irreversible finding of impairment or surgical value due to the compensable injury receive the full value awarded in these rules for the irreversible finding or surgical value.

Example: **Accepted conditions~~Compensable injury~~: Low back strain with herniated disk at L5-S1 and diskectomy.**

Noncompensable condition: pregnancy (mid-term)

The worker is released to regular work. In the closing examination, the attending physician describes range of motion findings and states that 60% of the range of motion loss is due to the accepted conditions~~compensable injury~~ and 40% of the range of motion loss is due to the pregnancy. Under these rules, the range of motion loss is valued at 10%. 10% x .60 equals 6%.

Diskectomy at L5-S1 (irreversible finding) = 9% per these rules.

Combine 9% with 6% for a value of 14% impairment for the compensable injury.

Statutory authority: ORS 656.726
Statutes implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist: Amended 1/29/15 as Admin. Order 15-053, eff. 3/1/15
Amended 4/10/17 as Admin. Order 17-054, eff. 4/11/17 (temp)
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