



# Oregon

Kate Brown, Governor

Department of Consumer and Business Services  
Workers' Compensation Division  
350 Winter St. NE  
P.O. Box 14480  
Salem, OR 97309-0405  
1-800-452-0288, 503-947-7810  
[www.wcd.oregon.gov](http://www.wcd.oregon.gov)

Sept. 15, 2017

## Proposed Changes to Workers' Compensation Rules

### Implementation of House Bills 2338 and 3363 (2017); other changes affecting claims administration

The Workers' Compensation Division proposes changes to OAR:

- [436-010, Medical Services](#)
- [436-060, Claims Administration](#)
- [436-075, Retroactive Program](#)

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?** Oct. 20, 2017, 9:30 a.m.
- Where is the hearing?** Labor & Industries Building  
350 Winter Street NE, Room F  
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](mailto: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 Oct. 26, 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

**FILED**  
9-15-17 2:36 PM  
ARCHIVES DIVISION  
SECRETARY OF STATE

Department of Consumer and Business Services, Workers' Compensation Division

436

Agency and Division

Administrative Rules Chapter Number

Fred Bruyins

(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**

Implementation of House Bills 2338 and 3363 (2017); other changes affecting claims administration

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

Hearing Date	Time	Location	Hearings Officer
10-20-17	9:30 a.m.	Room F, Labor & Industries Bldg, 350 Winter Street NE, Salem, Or	Fred Bruyins

**RULEMAKING ACTION**

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

**ADOPT:**

436-060, 436-060-0075

**AMEND:**

436-010-0210; 436-060, 436-060-0005, 436-060-0025, 436-060-0035, 436-060-0095, 436-060-0140, 436-060-0147, 436-060-0150, 436-075-0003, 436-075-0005, 436-075-0008, 436-075-0010, 436-075-0020, 436-075-0030, 436-075-0040, 436-075-0065, 436-075-0070, 436-075-0090

**REPEAL:**

436-075-0001, 436-075-0002, 436-075-0006

**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:**

656.210(2), 656.726(4)

**Other Authority:**

**Statutes Implemented:**

ORS 656, primarily 656.204 (House Bill 2338, 2017 Oregon Laws, chapter 71); 656.208, 656.210, 656.268, 656.325; ORS 677.100 to 677.228 and ORS 656.005 (House Bill 3363, 2017 Oregon Laws, chapter 409)

**RULE SUMMARY**

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

The agency proposes to amend OAR 436-010, Medical Services, to:

- Implement Enrolled House Bill 3363 (2017) by amending 436-010-0210, Appendix A, "Matrix for health care provider types" to refer to a "doctor of osteopathic medicine" rather than to a "doctor of osteopathy."

The agency proposes to amend OAR 436-060, "Claims Administration," to:

- Include a general definition of "dependent" in OAR 436-060-0005, plus a reference to ORS 656.005(10);
- Correct a typographical error in OAR 436-060-0025(4) to explain that the insurer may not include any gap in "earnings" (not "employment") of more than 14 days that was not anticipated in the wage earning agreement, when calculating the average earnings;
- Clarify in OAR 436-060-0025 that when a wage earning agreement has been changed due to reasons other than a pay raise, it is a new wage earning agreement;

- Implement Enrolled House Bill 2338 (2017) and consolidate several current provisions relevant to death benefits through adoption of a new rule describing appropriate payment of death benefits under ORS 656.204 and 656.208, to include provisions that address:
  - Final disposition of the body and funeral expenses;
  - Payments to surviving beneficiaries;
  - Benefit to surviving spouse;
  - Benefit to surviving child;
  - Benefit to surviving dependent;
  - Benefit to child or dependent attending higher education; and
  - Death during permanent total disability;
- Include in OAR 436-060-0095 the requirement, currently in OAR 436-010-0265(10)(b), for an insurer to forward a copy of the signed IME report to the attending physician to OAR 436-060-0095;
- Clarify in OAR 436-060-0140(6)(b)(B) that an "Updated Notice of Acceptance at Closure" is not necessary to begin payment of death benefits following a worker's death during a period of permanent total disability under ORS 656.208;
- Clarify requirements in OAR 436-060-0140 and 0147 affecting workers' rights to a worker-requested medical examination (WRME):
  - Specify in OAR 436-060-0147 that the director will determine the attending physician or authorized nurse practitioner does not concur with independent medical examination reports if the director does not receive documents that demonstrate the attending physician or authorized nurse practitioner concurs or does not concur with the reports within 30 days after the worker's request for hearing under 436-060-0147(1)(a);
  - Clarify in 436-060-0147(6) that the rule only requires the worker or worker's attorney to schedule a date for the WRME and inform the director and insurer of that scheduling within 14 days of the directors' notice, and that the WRME itself may take place outside of that 14-day window;
- Describe and clarify requirements in OAR 436-060-0150(6) for timely payment of death benefits; and
- Amend references to "fatal benefits" to "death benefits" to be consistent with the statute and OAR 436-075.

The agency proposes to amend OAR 436-075, "Retroactive Program," to:

- Remove obsolete and redundant provisions;
- Revise and reorganize several rules, including definitions, to enhance clarity, as well as consistency with other divisions of OAR chapter 436;
- Move several provisions regarding death benefits to OAR 436-060;
- Clarify in OAR 436-075-0005, OAR 436-075-0020, and OAR 436-075-0040 that statutory benefits will only be offset by a surviving spouse's Social Security benefits for claims with dates of injury between July 1, 1973, and April 1, 1974;
- Clarify in OAR 436-075-0065 that a disposition or claims settlement must be approved by the director before submission to the Workers' Compensation Board to be eligible for reimbursement from the Retroactive Program; and
- Explain that the insurer must use Form 3285, "Requests for Reimbursement from the Retroactive Program," or an equivalent form to request reimbursement from the Retroactive Program.

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.

10-26-2017 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.

**FILED**  
9-15-17 2:36 PM  
ARCHIVES DIVISION  
SECRETARY OF STATE

Department of Consumer and Business Services, Workers' Compensation Division  
Agency and Division

436  
Administrative Rules Chapter Number

Implementation of House Bills 2338 and 3363 (2017); other changes affecting claims administration

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

In the Matter of:

OAR 436-010, Medical Services  
OAR 436-060, Claims Administration  
OAR 436-075, Retroactive Program

**Statutory Authority:**

656.210(2), 656.726(4)

**Other Authority:**

**Statutes Implemented:**

ORS 656, primarily 656.204 (House Bill 2338, 2017 Oregon Laws, chapter 71); 656.208, 656.210, 656.268, 656.325; ORS 677.100 to 677.228 and ORS 656.005 (House Bill 3363, 2017 Oregon Laws, chapter 409)

**Need for the Rule(s):**

The agency has proposed rule changes primarily to implement legislation passed by the Oregon Legislature in 2017 and to better align some current rules with ORS chapter 656.

**Documents Relied Upon, and where they are available:**

Rulemaking advisory committee records, written advice, and Enrolled House Bills 2338 and 3363. 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 not have significant fiscal or economic impacts on the agency's costs to carry out its duties under ORS chapter 656. Projected effects on the public are described under "Statement of Cost of Compliance below.

**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 impacts on the cost of compliance of state agencies.
- b. The agency estimates that proposed rule changes will have no direct impacts on the cost of compliance of units of local government unless the government unit is a self-insured employer. See relevant impacts under c. below.
- c. The agency estimates that proposed rule changes will have the following effects on the public:

House Bill 2338 amended ORS 656.204 and 656.208 such that insurers and self-insured employers will pay some increased benefits, primarily to surviving children, following the death of a worker due to an on-the-job injury or illness. The proposed rules explaining requirements for processing and payment of death benefits are intended to promote understanding and compliance with the statutes, but the rules do not increase or decrease any benefit payable under the statutes.

Proposed amendments to procedures for worker-requested medical examinations (WRMEs) may result in an increase in the number of workers eligible for WRMEs. Workers' compensation insurers and self-insured employers assume the costs for WRMEs. Health care providers who perform WRMEs may see additional workers and receive additional payments. Workers who are able to obtain WRMEs may increase the likelihood of overturning insurers' denials of their claims, and therefore become eligible for workers' compensation indemnity and medical benefits. The agency cannot estimate how many additional WRMEs will be performed, and the associated costs and benefits, because the agency does not have data to show how many additional workers will be eligible for WRMEs.

Other proposed rule amendments should not result in a significant increase or decrease in the cost of compliance for any person or organization subject to the rules.

**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:**

Approximately 750 health care providers are eligible to perform WRMEs, and many of these providers are small businesses or are employed

by small businesses.

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

The agency projects that proposed rule changes will not increase or decrease the costs for reporting, recordkeeping, or other administrative activities required for compliance, including costs of professional services.

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

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

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

The agency reached out to more than 3,500 stakeholders, including small businesses, asking for advisory committee volunteers. The rulemaking advisory committee included representatives of small businesses.

**Administrative Rule Advisory Committee consulted?: Yes**

**If not, why?:**

10-26-2017 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*

### TABLE OF CONTENTS

**NOTE:** Revisions are marked as follows\*:

Deleted text has a "strike-through" style, as in ~~Deleted~~

Added text is underlined, as in Added

\*Only the "Matrix for health care provider types" has marked revisions.

## **436-010-0210 Attending Physician, Authorized Nurse Practitioner, and Time-Loss Authorization**

(1) An attending physician or authorized nurse practitioner is primarily responsible for the patient's care, authorizes time loss, and prescribes and monitors ancillary care and specialized care.

(a) No later than five days after becoming a patient's attending physician or authorized nurse practitioner, the provider must notify the insurer using [Form 827](#). Regardless of whether Form 827 is filed, the facts of the case and the actions of the provider determine if the provider is the attending physician or authorized nurse practitioner.

(b) Type A and B attending physicians and authorized nurse practitioners may authorize time loss and manage medical services subject to the limitations of ORS chapter 656 or a managed care organization contract. (See Appendix A "Matrix for Health Care Provider Types")

(c) Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be approved by the worker's attending physician or authorized nurse practitioner.

### **(2) Chiropractic Physicians, Naturopathic Physicians, Physician Assistants (Type B providers).**

(a) Prior to providing any compensable medical service or authorizing temporary

**ORDER NO. 17-XXX**

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
WORKERS' COMPENSATION DIVISION  
MEDICAL SERVICES RULES**

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disability benefits under ORS 656.245, a type B provider must certify to the director that the provider has reviewed a packet of materials provided by the director.

(b) Type B providers may assume the role of attending physician for a cumulative total of 60 days from the first visit on the initial claim or for a cumulative total of 18 visits, whichever occurs first.

(c) Type B providers may authorize payment of temporary disability compensation for a period not to exceed 30 days from the date of the first visit on the initial claim to any type B provider.

(d) Except for chiropractic physicians serving as the attending physician at the time of claim closure, type B providers may not make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.

### **(3) Emergency Room Physicians.**

Emergency room physicians may authorize time loss for no more than 14 days when they refer the patient to a primary care physician. If an emergency room physician sees a patient in his or her private practice apart from their duties as an emergency room physician, the physician may be the attending physician.

### **(4) Authorized Nurse Practitioners.**

(a) In order to provide any compensable medical service, a nurse practitioner licensed in Oregon under ORS 678.375 to 678.390 must review a packet of materials provided by the division and complete the statement of authorization. (See [www.oregonwcdoc.info](http://www.oregonwcdoc.info)) Once the nurse practitioner has completed the statement of authorization, the division will assign an authorized nurse practitioner number.

(b) An authorized nurse practitioner may:

(A) Provide compensable medical services to an injured worker for a period of 180 days from the date of the first visit with a nurse practitioner on the initial claim. Thereafter, medical services provided by an authorized nurse practitioner are not compensable without the attending physician's authorization; and

(B) Authorize temporary disability benefits for a period of up to 180 days from

the date of the first nurse practitioner visit on the initial claim.

**(5) Unlicensed to Provide Medical Services.**

Attending physicians may prescribe services to be carried out by persons not licensed to provide a medical service or treat independently. These services must be rendered under the physician's direct control and supervision. Home health care provided by a patient's family member is not required to be provided under the direct control and supervision of the attending physician if the family member demonstrates competency to the satisfaction of the attending physician.

**(6) Out-of-State Attending Physicians.**

The worker may choose an attending physician outside the state of Oregon with the approval of the insurer. When the insurer receives the worker's request or becomes aware of the worker's request to treat with an out-of-state attending physician, the insurer must give the worker written notice of approval or disapproval of the worker's choice of attending physician within 14 days.

**(a)** If the insurer approves the worker's choice of out-of-state attending physician, the insurer must immediately notify the worker and the physician in writing of the following:

- (A)** The Oregon medical fee and payment rules, OAR 436-009;
- (B)** The manner in which the out-of-state physician may provide compensable medical treatment or services to Oregon workers; and
- (C)** That the insurer cannot pay bills for compensable services above the Oregon fee schedule.

**(b)** If the insurer disapproves the worker's out-of-state attending physician, the notice to the worker must:

- (A)** Clearly state the reasons for the disapproval, for example, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010,
- (B)** Identify at least two other physicians of the same healing art and specialty in the same area that the insurer would approve, and
- (C)** Inform the worker that if the worker disagrees with the disapproval, the worker may request approval from the director under OAR 436-010-0220.

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(7) If an approved out-of-state attending physician does not comply with OAR 436-009 or 436-010, the insurer may withdraw approval of the attending physician. The insurer must notify the worker and the physician in writing:

(a) The reasons for withdrawing the approval,

(b) That any future services provided by that physician will not be paid by the insurer, and

(c) That the worker may be liable for payment of services provided after the date of notification.

(8) If the worker disagrees with the insurer's decision to disapprove an out-of-state attending physician, the worker or worker's representative may request approval from the director under OAR 436-010-0220.

**Stat. Auth:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.005(12), 656.245, 656.260, 656.799

**Hist:** Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

**Amended 3/6/17 as Admin.** Order 17-051, eff. 4/1/17

**Amended xx/xx/xx as Admin.** Order xx-xxx, eff. 1/1/2018

See also the *Index to Rule History*: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
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**Appendix A - Matrix for health care provider types \***

See OAR 436-010-0210

	Attending physician status (primarily responsible for treatment of a patient's injury)	Provide compensable medical services for initial injury or illness	Authorize payment of time loss (temporary disability) and release the patient to work	Establish impairment findings (permanent disability)	Provide compensable medical services for aggravation of injury or illness
Type A attending physician Medical doctor Doctor of osteopathic medicine Oral and maxillofacial surgeon Podiatric physician and surgeon	Yes	Yes	Yes	Yes	Yes
Type B attending physician Chiropractic physician Naturopathic physician Physician assistant	Yes, for a total of 60 consecutive days or 18 visits, from the date of the initial visit on the initial claim with any Type B attending physician.	Yes, unless the total of 60 consecutive days or 18 visits from the date of the initial visit on the initial claim with any Type B attending physician has passed. Or, if authorized by an attending physician and under a treatment plan. (Note: physician assistants are not required to have a written treatment plan)	Yes, 30 days from the date of the first visit with any type B attending physician on the initial claim, if within the specified 18 visit period.	No, unless the type B attending physician is a chiropractic physician.	No Unless authorized by attending physician and under a written treatment plan (Note: physician assistants are not required to have a written treatment plan)
Emergency room physicians	No, if the physician refers the patient to a primary care physician	Yes	ER physicians may authorize time loss for up to 14 days only, including retroactive authorization	No if patient referred to a primary care physician	Yes
Authorized nurse practitioner	No	Yes, for 180 consecutive days from the date of the first visit to any authorized nurse practitioner on the initial claim. Or if authorized by attending physician.	Yes, for 180 days from the date of the first visit on the initial claim.	No	No Unless authorized by the attending physician
Other health care providers e.g., acupuncturists	No	Yes, for 30 consecutive days or 12 visits from the date of the first visit on the initial claim with any other health care providers. Thereafter, services must be provided under a treatment plan and authorized by the attending physician.	No	No	No, unless referred by the attending physician and under a written treatment plan

\* This matrix does not apply to Managed Care Organizations



DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
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**Claims Administration  
Oregon Administrative Rules  
Chapter 436, Division 060**

*Proposed*

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**NOTE:** Revisions are marked as follows: new text | ~~deleted text~~.

**Historical rules:** [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf)

OREGON ADMINISTRATIVE RULES  
CHAPTER 436, DIVISION 060

**436-060-0005 Definitions**

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made a part of these rules. For the purpose of these rules unless the context requires otherwise:

(1) "Aggravation" means an actual worsening of the compensable conditions after the last award or arrangement of compensation that satisfies the requirements of ORS 656.273.

(2) "Authorized nurse practitioner" means a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010.

(3) "Dependent" means any of the relatives of a worker listed under ORS 656.005(10) who, at the time of an accident, depended in whole or in part for support on the earnings of a worker who dies as a result of an injury.

(34) "Designated paying agent" means the insurer temporarily ordered responsible to pay compensation for a compensable injury under ORS 656.307.

(45) "Director" means the Director of the Department of Consumer and Business Services or the director's designee, unless the context requires otherwise.

(56) "Disposition" or "claim disposition" means the written agreement to release rights or obligations under ORS 656.236.

(67) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(78) "Employer" means a subject employer under ORS 656.023.

(89) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(910) "Inpatient" means a worker who is admitted to a hospital before and extending past midnight for treatment and lodging.

(1011) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon; or an employer or employer group certified under ORS 656.430 that it meets the qualifications of a self-insured employer under ORS 656.407.

(1112) "Mailed" or "mailing date," unless otherwise specified, means:

- (a) The date a document is postmarked;
- (b) The date automatically produced by electronic transmission (e.g., email or facsimile);
- (c) The date a hand-delivered document is stamped or punched in by the recipient; or
- (d) The date of a phone, or in-person request, when allowed under these rules.

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CLAIMS ADMINISTRATION**

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**(4213)** “Physical rehabilitation program” means any services provided to a worker to prevent the compensable injury from causing continuing disability.

**(4314)** “Regularly employed worker” means any worker who receives a regular wage as defined in section (16) of this rule. For workers who are paid a daily wage, “regularly employed” means actual employment or availability for such employment.

**(4415)** “Service company” means the contracted agent for an insurer authorized to process claims and make payment of compensation on behalf of the insurer.

**(4516)** “Suspension of compensation” means:

(a) No temporary disability, permanent total disability, or medical and related service benefits accrue or are payable during the period of suspension; and

(b) Vocational assistance and payment of permanent partial disability benefits will stop during the period of suspension.

**(4617)** “Wage” is as defined in ORS 656.005(29). As used in these rules:

(a) “Irregular wage” means a money rate paid at variable rate, or is paid on unscheduled or unpredictable intervals, including but not limited to workers who are seasonally employed, on call, paid hourly, or are paid by piece rate; and

(b) “Regular wage” means a money rate which is paid at a constant rate at uniform intervals including, but not limited to, wages paid on a daily or weekly basis. Hourly wages may be considered regular if the same number of hours are worked each pay period.

**(4718)** “Wage earning agreement” means the verbal or written contract of hiring or terms of employment made between the worker and employer.

**(4819)** “Written” means expressed in writing, including electronic transmission.

Statutory authority: 656.726(4)

Statutes implemented: 656.726(4)

Hist: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16

Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17

[Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18](#)

See also the Index to Rule History: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

### **436-060-0025 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.**

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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;
- (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. 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) Rate of compensation, irregular wages.**

If a worker receives irregular wages, or receives earnings that are not based on wages alone, the insurer must calculate the worker's rate of compensation under section (3) of this rule based on the weekly average of the worker's total earnings for the period up to 52 weeks before the date of injury or verification of disability caused by occupational disease.

- (a) [As used in this section:](#)

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WORKERS' COMPENSATION DIVISION  
CLAIMS ADMINISTRATION**

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(A) "Total earnings" means all wages, salary, commission and other remuneration for services rendered under the worker's wage earning agreement with the employer.

(Ai) The insurer must include a reasonable value of any in-kind considerations as part of total earnings only if the considerations will not continue during the period of disability.

(Bii) The insurer must not include expenses incurred due to the job and reimbursed by the employer (e.g., meals, lodging, per diem, equipment rental) as part of total earnings.

(B) "New wage earning agreement" means the worker's wage earning agreement changed for reasons other than only a change in rate of pay, 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 436-050 is not considered to be a new wage earning agreement.

(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, the insurer must average the workers' total earnings 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 may not include any gap in employment earnings of more than 14 days that was not anticipated in the wage earning agreement, when calculating the average earnings; ~~and~~

(B) If the worker's began work under a new wage earning agreement ~~changed due to reasons other than only a change in rate of pay, including but not limited to a change of hours worked or a change of job duties~~, in the 52 weeks before the date of injury or verification of disability caused by occupational disease, the insurer must average earnings only for the weeks worked under the most recent wage earning agreement.; ~~and~~

~~(C) For the purposes of this section, a job assignment from a temporary service provider or worker leasing company as defined in OAR 436-050 is not considered to be a new wage earning agreement.~~

(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 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) Rate of compensation, regular wages.**

If a worker receives regular wages, the insurer must calculate the worker's rate of compensation as outlined in ORS 656.210. To determine the worker's weekly wage:

(a) Daily wages must be multiplied by the number of days per week the worker was regularly employed;

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(b) Monthly wages must be divided by 4.35; or

(c) Wages for other pay intervals must be calculated on an equivalent basis.

**(6) Workers with no wages.**

If the worker is a volunteer, inmate, or other covered worker that receives no wage earnings, 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 authority: ORS 656.210(2), 656.704, and 656.726(4)

Statutes implemented: ORS 656.210, 656.704

Hist: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17

[Amended xx/xx/xx as WCD Admind. Order 17-XXX, eff. 1/1/18](#)

See also the Index to Rule History: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

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

**(1) Definitions.**

For the purpose of this rule:

(a) "Primary job" means the job at which the injury occurred, or the job where the worker was employed at the time of medical verification that the worker is unable to work because of disability caused by occupational disease;

(b) "Secondary job" means any other job held by the worker in Oregon subject employment at the time of injury;

(c) "Temporary disability" means wage loss replacement for the primary job.

(d) "Supplemental disability" means wage loss replacement for the secondary jobs that exceeds the temporary disability, up to, but not exceeding, the maximum established by ORS 656.210; and

(e) "Insurer" has the same meaning as OAR 436-060-0005~~(10)~~(11), and also includes service companies.

**(2) Election to process and pay supplemental disability.**

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An insurer may elect to be responsible for payment and processing of supplemental disability benefits to a worker employed in more than one job at the time of injury. The insurer must report their election to the director under OAR 436-060-0011(12).

- (a) The election must be made by the insurer, and applies to all service companies an insurer may use for processing claims.
- (b) The election remains in effect for all supplemental disability claims the insurer receives until the insurer changes its election. An insurer may change its election once after the director's first audit of supplemental disability payments made by the insurer and once each following year.
- (c) If the insurer has elected to process and pay supplemental disability benefits:
  - (A) The insurer must determine the worker's ongoing entitlement to supplemental disability;
  - (B) The insurer must pay the worker supplemental disability benefits simultaneously with any temporary disability benefits due;
  - (C) The insurer must maintain a record of supplemental disability benefits paid to the worker, separate from temporary disability benefits paid as a result of the job at injury; and
  - (D) The director will reimburse the insurer for supplemental disability paid under OAR 436-060-0500.
- (d) If the insurer has elected not to process and pay supplemental disability benefits:
  - (A) The director will select an assigned processing administrator who is authorized to process and pay supplemental disability benefits on behalf of the director;
  - (B) The assigned processing administrator must determine the worker's ongoing entitlement to supplemental disability and must pay the worker supplemental disability benefits due once each 14 days; and
  - (C) The insurer and assigned processing administrator must cooperate and communicate, as necessary, to coordinate benefits due.
    - (i) The assigned processing administrator must provide the insurer with any verifiable documentation of wages from a secondary job received from the worker; and
    - (ii) The insurer and assigned processing administrator must retain documentation of shared information.

**(3) Eligibility for supplemental disability.**

A worker who was employed at one or more secondary jobs with Oregon subject employers at the time of injury or medical verification of an occupational disease may be eligible to receive supplemental disability if:

- (a) The worker provides notification of the secondary job to the insurer within 30 days of the insurer's receipt of the initial claim;

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(b) The rate of compensation for wages at the primary job under OAR 436-060-0025 is less than the maximum temporary disability rate established under ORS 656.210; and

(c) The worker provides verifiable documentation of the wages from any secondary jobs at the time of injury or medical verification of an occupational disease within 60 days of the mailing date of the request for documentation sent under section (4) of this rule. For each secondary job, the documentation must:

(A) Identify the Oregon subject employer for each secondary job;

(B) Establish that the worker held the secondary job, in addition to the primary job, at the time of injury or medical verification of occupational disease; and

(C) Provide adequate information to calculate the average weekly wage under OAR 436-060-0025.

**(4) Determination of eligibility.**

Upon receiving notification of a worker's secondary job the insurer must determine the rate of temporary disability compensation for wages at the primary job under OAR 436-060-0025, and:

(a) If the rate of temporary disability compensation meets or exceeds the maximum temporary disability rate, the worker is not eligible for supplemental disability benefits; or

(b) If the rate of temporary disability is less than the maximum temporary disability rate, the worker may be eligible for supplemental disability benefits. If the worker may be eligible for supplemental disability benefits, the insurer must:

(A) Send the worker a request for verifiable documentation of the worker's wages from any secondary jobs within five business days of notice or knowledge that the worker may be eligible for supplemental disability benefits;

(i) The request must inform the worker what verifiable documentation the worker must submit to the insurer or assigned processing administrator, to determine the worker's eligibility for supplemental disability;

(ii) The request must clearly state that if the insurer or assigned processing administrator does not receive the required documentation within 60 days of the mailing date of the request, the insurer will determine the worker's temporary disability rate based only on the job at which the injury occurred, and the worker will be found ineligible for supplemental disability;

(B) If the insurer has elected not to process and pay supplemental disability benefits under section (2) of this rule, the insurer must also send a copy of the request to the assigned processing administrator. In addition to the requirements of this section, the request must also:

(i) Contain the name, address, email address, and telephone number of the assigned processing administrator;

(ii) Clearly advise the worker that the verifiable documentation must be sent to

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the assigned processing administrator; and

(C) The insurer or assigned processing administrator must determine the worker's eligibility for supplemental disability within 14 days of:

(i) Receipt of the worker's verifiable documentation; or

(ii) The end of the 60-day period in the insurer's request, if the worker does not provide verifiable documentation.

(c) Any delay in the payment of a higher disability rate because of the worker's failure to provide verifiable documentation under this section will not result in a penalty under ORS 656.262(11).

**(5) Notification of eligibility determination.**

The insurer or the assigned processing administrator must determine the worker's eligibility for supplemental disability and must communicate the determination to the worker and the worker's attorney, if any, in writing. If the worker is found ineligible for supplemental disability, the letter must also advise the worker of the reason why they are not eligible, and how to appeal if the worker disagrees with the determination.

**(6) Calculation of supplemental disability.**

The insurer or the assigned processing administrator must calculate supplemental disability for an eligible worker by adding the weekly averages of the worker's wages from each secondary job as calculated under OAR 436-060-0025. For the purposes of calculating and payment of supplemental disability:

(a) The total rate of supplemental disability may not exceed the difference between the maximum rate of temporary disability under ORS 656.210(1) and the rate of compensation for wages under the worker's primary job;

(b) No supplemental disability is due for jobs where the rate of compensation is based on an assumed wage;

(c) In no case may an eligible worker receive less compensation than would be paid if based solely on wages from the primary employer;

(d) The worker's scheduled days off for the primary job must be used to calculate and pay supplemental disability; and

(e) No three-day waiting period applies to supplemental disability benefits.

**(7) Partial disability.**

When a worker who is eligible to receive supplemental disability benefits has post-injury wages from either the primary job or any secondary job:

(a) The insurer or the assigned processing administrator must calculate the rate of temporary partial disability due the worker under OAR 436-060-0030 based on the worker's wages from both the primary and secondary jobs;

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(b) The insurer or the assigned processing administrator must calculate the amount of supplemental disability by subtracting the rate of partial disability due based on wages from only the primary job from the total rate of compensation due the worker;

(c) If the worker receives post-injury wages from the secondary job equal to or greater than the secondary wages at the time of injury, no supplemental disability is due; and

(d) If the worker returns to a job not held at the time of the injury, the insurer or the assigned processing administrator must process supplemental disability under the same terms, conditions and limitations as OAR 436-060-0030.

**(8) If temporary disability is not due from the primary job.**

Supplemental disability may be due on a nondisabling claim even if temporary disability is not due from the primary job.

(a) A nondisabling claim will not change to disabling status due to payment of supplemental disability.

(b) When supplemental disability payments cease on a nondisabling claim, the insurer or the assigned processing administrator must send the worker written notice advising the worker that their supplemental disability payments have stopped and of the worker's right to appeal that action to the Workers' Compensation Board within 60 days of the notice, if the worker disagrees.

**(9) Worker's responsibilities.**

A worker who is eligible for supplemental disability under this rule has an ongoing responsibility to provide information and documentation to the insurer or the assigned processing administrator, even if temporary disability is not due from the primary job.

**(10) Hearings.**

If a worker disagrees with the insurer's or the assigned processing administrator's decision about the worker's eligibility for supplemental disability or the rate of supplemental disability, the worker may request a hearing under OAR 436-060-0008.

(a) If the worker requests a hearing on the insurer's decision concerning the worker's eligibility for supplemental disability, the worker must submit an appeal of the insurer's or the assigned processing administrator's decision within 60 days of the notice in section (5) of this rule.

(b) The insurer for the primary job is not required to contact the secondary job employer. The worker is responsible to provide any necessary documentation.

**(11) Sanctions.**

An insurer that elects not to process and pay supplemental disability benefits may be sanctioned upon a worker's complaint if the insurer delays sending necessary information to the assigned processing administrator and that delay causes a delay in the worker receiving supplemental disability benefits.

**(12) Third party recovery.**

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In the event of a third party recovery:

- (a) Previously reimbursed supplemental disability benefits are a portion of the paying agency's lien; and
- (b) Remittance on recovered benefits must be made to the department in the quarter following the recovery in amounts determined in accordance with ORS 656.591 and ORS 656.593.

Statutory authority: ORS 656.210 and 656.726(4)

Statutes implemented: ORS 656.210, 656.212, 656.325(5), 656.704, 656.726(4)

Hist: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16

Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17

Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18

See also the Index to Rule History: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

**436-060-0075      -Payment of Death Benefits**

If death results from a workers' compensable injury or occupational disease, benefits must be paid according to ORS 656.204 and this rule:

**(1) Final disposition of the body and funeral expenses.**

- (a) The insurer must pay the cost of final disposition of the body and funeral expenses, up to the maximum benefit under ORS 656.204(1); and
- (b) The worker's estate, beneficiaries, or other parties may submit bills related to final disposition of the body and funeral up to 60 days after the date of death or date of claim acceptance, whichever is later. Any portion of the benefit that remains unpaid after this period must be paid to the estate of the worker.

**(2) Payments to surviving beneficiaries.**

The following applies to benefits paid under sections (3) through (5) of this rule:

- (a) Benefits payable for a partial month must be calculated by dividing the monthly benefit by the actual number of days in the month and multiplying that result by the number of days payable;
- (b) Unless otherwise specified, monthly benefits to beneficiaries must be paid up to the date of any status change; and
- (c) Payments must be paid within the timeframes established in OAR 436-060-0150(6).

**(3) Benefit to surviving spouse.**

If a worker is survived by a spouse, the insurer must pay monthly benefits in an amount equal to 4.35 times 66-2/3 percent of the average weekly wage to the surviving spouse. Benefits under this section must be paid through the end of the month in which the spouse is no longer eligible to receive benefits.

**(4) Benefit to surviving child.**

If a worker is survived by a child under 19 years of age, the insurer must pay a monthly benefit to each child equal to 4.35 times 25 percent of the state average weekly wage, subject to the following:

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(a) Total monthly benefits paid under this section must not exceed 4.35 times 133-1/3 percent of the average weekly wage. If the sum of the individual benefits exceeds this maximum, the insurer must reduce the benefit for each child proportionally;

(b) The insurer may make payment of benefits due under this section to the child's parent, legal guardian, or person having custody of the child. If the child becomes sui juris, the insurer must begin making payment of benefits directly to the child immediately upon the child's written request; and

(c) The insurer must send each child Form 5332, "Notice to Beneficiary of Entitlement to Benefits" at least 90 days before their 18<sup>th</sup> birthday, informing the child of his or her right to receive benefit payments directly under subsection (b), and of his or her entitlement to higher education benefits.

**(5) Benefit to surviving dependent.**

If a worker is survived by a dependent, the insurer must pay a monthly benefit to each dependent that is equal to 50 percent of the average monthly support the dependent actually received from the worker during the 12 months preceding the occurrence of the accidental injury, subject to the following:

(a) Payments to the dependent must continue until:

(A) When the dependent becomes 19 years of age, if the dependent is under the age of 19 years at the time of the accidental injury; or

(B) Under the same circumstances that would have terminated the dependency had the injury not happened, if the dependent is 19 years of age or older at the time of the accidental injury;

(b) Within five business days after the date of receipt of a request for benefits from an eligible dependent, the insurer must send the dependent a request for verifiable documentation of the support the dependent actually received from the worker during the 12 months preceding the occurrence of the accidental injury. The request must:

(A) Inform the dependent what verifiable documentation the dependent must submit to the insurer to calculate the dependent's benefit; and

(B) Clearly state that if the insurer does not receive the required documentation within 60 days of the mailing date of the request, the insurer will determine the dependent's monthly benefit based only on the information in the insurers possession;

(c) Upon receipt of verifiable documentation or the expiration of the 60 day period in paragraph (5)(c)(B) of this rule, the insurer must:

(A) Determine the dependent's monthly benefit and commence payment under OAR 436-060-0150(6); or

(B) Notify the dependent that the information in the insurer's possession was not sufficient to determine the dependent's monthly benefit and provide information about how the dependent may appeal this decision; and

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(d) As used in this section, "verifiable documentation" means any written record of financial support provided to the dependent by the worker including, but not limited to, receipts, billing statements, bank account statements, or signed affidavits.

**(6) Benefit to child or dependent attending higher education.**

The insurer must pay up to 48 months of benefits during any period in which an eligible child or dependent is between the ages of 19 and 26 and is completing secondary education, is obtaining a general educational development certificate, or is attending a program of higher education, including vocational or technical training.

(a) Benefits under this section must be paid for an entire month. The child or dependent may claim a full month's benefit for any month in which the child is completing secondary education, obtaining a general educational development certificate or attending a program of higher education for at least one day.

(b) The child or dependent must provide the insurer with documentation that enables the insurer to determine the child's or dependent's eligibility for monthly benefits.

(A) As used in this section, "documentation" includes, but is not limited to, verification of enrollment in a secondary school, general education development certificate program, or program of higher education.

(B) The child or dependent may use Form 5332, "Notice to beneficiary of entitlement to benefits" to satisfy the requirements of this section.

**(7) Death during permanent total disability.**

If a worker dies during a period of permanent total disability:

(a) The insurer must pay the costs of final disposition of the body and funeral expenses in the same manner and same amounts as provided in ORS 656.204(1) and section (1) of this rule, subject to the following:

(A) For claims with a date of injury before July 1, 1973, burial benefits are due only if death results from the accidental injury causing the permanent total disability; and

(B) For claims with a date of injury on or after July 1, 1973:

(i) Burial benefits are due if death results from the accidental injury causing the permanent total disability; or

(ii) Burial benefits are due regardless of the reason for death, if the worker was survived by an eligible beneficiary;

(b) The insurer must pay benefits to surviving beneficiaries in the same manner and same amounts as provided in ORS 656.204 and section (2) through (6) of this rule:

(A) Permanent total disability benefits must be paid through the date of death. Benefits under this section begin to accrue the following calendar day; and

(B) Benefits payable for a partial month must be calculated by dividing the monthly benefit by the actual number of days in the month and multiplying that result by the number of days payable;

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(c) The insurer is not required to reopen and close the claim to begin making payments under this section; and

(d) The insurer may not recover an overpayment of permanent total disability benefits under ORS 656.268(14) from benefits payable to a beneficiary other than the beneficiary that received the overpayment.

Statutory authority: 656.726(4)

Statutes implemented: ORS 656.204; 656.208; 656.268(14)

Hist: Adopted xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18

See also the Index to Rule History: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf)

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

**(1) General.**

A worker must submit to independent medical examinations reasonably requested by the insurer or the director.

(a) The conditions of the examination must be consistent with conditions described in OAR 436-010-0265.

(b) If the worker refuses or fails to submit to, or otherwise obstructs, an independent medical examination reasonably requested by the insurer or the director under ORS 656.325(1), the director may suspend compensation by order:

(A) The worker must have the opportunity to dispute the suspension of compensation before the director will issue the order; and

(B) Compensation will be suspended until the examination has been completed. The worker is not entitled to compensation during or for the period of suspension.

(c) Any action of a worker's observer allowed under OAR 436-010-0265(5) that obstructs the examination may be considered an obstruction of the examination by the worker for the purpose of this rule.

(d) The director may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination.

**(2) Number of examinations.**

The insurer may request no more than three separate independent medical examinations for each opening of a claim, except as provided under OAR 436-010. Examinations after the worker's claim is closed are subject to limitations in ORS 656.268(8).

**(3) Scheduling and notice to worker.**

The insurer may contract with a third party to schedule independent medical examinations. When an examination is scheduled by the insurer, or by a third party at the request of the insurer:

(a) The worker and the worker's attorney, if any, must be simultaneously notified in writing of the scheduled medical examination;

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- (b) The notice must be mailed at least 10 days before the examination;
- (c) If the third party notifies the worker of a scheduled examination on behalf of the insurer, the appointment notice must be sent on the insurer's stationery; and
- (d) The notice sent for each appointment, including those which have been rescheduled, must contain the following:
  - (A) The name of the examiner or facility;
  - (B) A statement of the specific purpose for the examination and, identification of the medical specialties of the examiners;
  - (C) The date, time and place of the examination;
  - (D) The first and last name of the attending physician or authorized nurse practitioner and verification that the attending physician or authorized nurse practitioner was informed of the examination by, at least, a copy of the appointment notice, or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;
  - (E) If applicable, confirmation that the director has approved the examination;
  - (F) A statement that the reasonable cost of public transportation or use of a private vehicle will be reimbursed and that, when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance;
  - (G) A statement that an amount will be paid equivalent to net lost wages for the period during which it is necessary to be absent from work to attend the medical examination if benefits are not received under ORS 656.210(4) during the absence;
  - (H) A statement that the worker has the right to have an observer present at the examination, but the observer may not be compensated in any way for attending the exam; however, for a psychological examination, the notice must explain that an observer is allowed to be present only if the examination provider approves the presence of an observer; and
  - (I) The following notice in prominent or bold face type:

**“You must attend this examination. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the examination. If you fail to attend and do not have a good reason for not attending, or you fail to cooperate with the examination, your workers’ compensation benefits may be suspended in accordance with the workers’ compensation law and rules, ORS 656.325 and OAR 436-060. You may be charged a \$100 penalty if you fail to attend without a good reason or if you fail to notify the insurer before the examination. The penalty is taken out of future benefits.**”

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**If you object to the location of this appointment you must contact the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 or the Ombudsman for Injured Workers at 1-800-927-1271."**

- (e) The insurer must include with each appointment notice it sends to the worker:
- (A) Form 3921, "Request for Reimbursement of Expenses," or a similar form for requesting reimbursement; and
  - (B) Form 3923, "Important Information about Independent Medical Exams."

**(4) Reimbursement of costs.**

The insurer must reimburse the worker for a reasonable cost of public transportation or use of a private vehicle and, when necessary, a reasonable cost of child care, meals, lodging and other related services.

- (a) To be reimbursed, the worker must submit a request for reimbursement accompanied by a sales slip, receipt or other evidence necessary to support the request.
- (b) If an advance of these costs is necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance.
- (c) Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, are considered to be reasonable under this rule.

**(5) Forwarding of reports from provider.**

Following completion of the examination, the insurer must forward a copy of the examiner's signed report to the attending physician or authorized nurse practitioner within three days, excluding weekends and legal holidays, of the insurer's receipt of the report.

**(5) Requests to authorize suspension.**

The director will consider requests to authorize suspension of benefits on accepted claims, deferred claims, and denied claims in which the worker has appealed the insurer's denial. The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service in the same manner as a summons. The request must include the following information:

- (a) That the insurer requests suspension of compensation under ORS 656.325 and OAR 436-060-0095;
- (b) The claim status and any accepted or newly claimed conditions;
- (c) What specific actions of the worker prompted the request;
- (d) The dates of any prior independent medical examinations the worker has attended in the current open period of the claim and the names of the examining physicians or

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facilities, or a statement that there have been no prior examinations, whichever is appropriate;

(e) A copy of any approvals given by the director for more than three independent medical examinations, or a statement that no approval was necessary, whichever is appropriate;

(f) Any reasons given by the worker for failing to comply, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;

(g) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the exam received by the insurer from the worker or the worker's attorney will be sufficient documentation with which to request suspension;

(h) A copy of the notice required in section (3) and a copy of any written verification received under subsection (5)(g) of this rule;

(i) Any other information that supports the request; and

(j) The following notice in prominent or bold face type:

**“Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers’ Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the mailing date of this request. If the division grants this request, you may lose all or part of your benefits. If your claim has not yet been accepted, your future benefits, if any, will be jeopardized.”**

**(67) Effective date of suspension.**

If the director authorizes the suspension of compensation, the suspension will be effective from the date the worker fails to attend an examination or such other date the director deems appropriate until the date the worker undergoes an examination scheduled by the insurer or director. Any delay in requesting consent for suspension may result in authorization being denied or the date of authorization being modified.

**(78) Reinstatement of benefits.**

The insurer must assist the worker in meeting requirements necessary for the resumption of compensation payments. When the worker has undergone the independent medical examination, the insurer must verify the worker's participation and reinstate compensation effective the date of the worker's compliance.

**(89) Claim closure.**

If the worker makes no effort to reinstate compensation in an accepted claim within 60 days of the mailing date of the consent to suspend order, the insurer must close the claim under OAR 436-030-0034(8).

**(910) Denial of suspension.**

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If the director denies the insurer's request for suspension of compensation, the insurer will be notified of the reason for denial. Failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.

**(4011) Other actions by the director.**

The director may also take the following actions concerning the suspension of compensation:

- (a) Modify or set aside the order of consent before or after a request for hearing is filed;
- (b) Order payment of compensation previously suspended when the director finds the suspension to have been made in error; and
- (c) Reevaluate the necessity of continuing a suspension.

**(4112) Final orders.**

An order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division.

Statutory authority: ORS 656.325, 656.704, and 656.726(4)  
Statutes implemented: ORS 656.325, 656.704, and 656.726(4)  
Hist: Amended 3/1/11 as Admin. Order 11-052, eff. 4/1/11  
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17  
[Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18](#)  
See also the Index to Rule History: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

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

**(1) Claim investigations.**

The insurer is required to conduct a "reasonable" investigation based on all available information in determining whether to deny a claim.

- (a) A reasonable investigation is whatever steps a reasonably prudent person with knowledge of the legal standards for determining compensability would take in a good faith effort to ascertain the facts underlying a claim, giving due consideration to the cost of the investigation and the likely value of the claim.
- (b) In determining whether an investigation is reasonable, the director will only look at information contained in the insurer's claim record at the time of denial. The insurer may not rely on any fact not documented in the claim record at the time of denial to establish that an investigation was reasonable.

**(2) Notice to worker.**

The insurer must give the worker written notice of acceptance or denial of a claim within the following time frames:

- (a) For claims with a date of injury before January 1, 2002, within 90 days of:
  - (A) The employer's notice or knowledge of an initial claim;
  - (B) The insurer's receipt of a Form 827 signed by the worker or the worker's attorney, and the worker's attending physician indicating an aggravation claim; or
  - (C) Written notice of a new medical condition claim;

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- (b) For claims with a date of injury on or after January 1, 2002, within 60 days after:
- (A) The employer's notice or knowledge of an initial claim
  - (B) The insurer's receipt of a Form 827 signed by the worker or the worker's attorney and the worker's attending physician indicating an aggravation claim; or
  - (C) Written notice of a new medical or omitted condition claim; or
- (c) For claims with any date of injury, if the worker challenges the location of an independent medical examination under OAR 436-010-0265 and the challenge is upheld, within 90 days after the employer's notice or knowledge of the claim.

**(3) Penalty for untimely acceptance and denials.**

The director may assess a penalty under OAR 436-060-0200 against any insurer delinquent in accepting or denying a claim beyond the time frame required under section (2) of this rule

**(4) Notice of acceptance.**

A notice of acceptance must comply with ORS 656.262(6)(b) and OAR chapter 438. It must include a current mailing date, be addressed to the worker, be copied to the worker's attorney, if any, and the worker's attending physician, and describe to the worker:

- (a) What conditions are compensable;
- (b) Whether the claim is disabling or nondisabling;
- (c) The Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that the injury is nondisabling by requesting the insurer review the status;
- (d) The employment reinstatement rights and responsibilities under ORS chapter 659A;
- (e) Assistance available to employers from the Re-employment Assistance Program under ORS 656.622;
- (f) That claim related expenses paid by the worker must be reimbursed by the insurer when requested in writing and accompanied by sales slips, receipts, or other reasonable written support, for meals, lodging, transportation, prescriptions and other related expenses. The worker must be advised of the two year time limitation to request reimbursement as provided in OAR 436-009-0025 and that reimbursement of expenses may be subject to a maximum established rate;
- (g) That if the worker believes a condition has been incorrectly omitted from the notice of acceptance, or the notice is otherwise deficient, the worker must first communicate the objection to the insurer in writing specifying either that the worker believes the condition has been incorrectly omitted or why the worker feels the notice is otherwise deficient; and
- (h) That if the worker wants the insurer to accept a claim for a new medical condition, the worker must put the request in writing, clearly identify the condition as a new medical condition, and request formal written acceptance of the condition.

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**(5) Notice of acceptance, fatal claims.**

In the case of a fatal claim, the notice must be addressed "to the estate of" the worker and the requirements of subsection (4)(a) through (h) of this rule must not be included.

**(6) Initial, updated, and modified notices of acceptance.**

(a) The first acceptance issued on the claim must contain the title "Initial Notice of Acceptance" near the top of the notice. Any notice of acceptance must contain all accepted conditions at the time of the notice.

(b) When an insurer closes a claim, it must issue an "Updated Notice of Acceptance at Closure" under OAR 436-030-0015.

(A) To correct an omission or error in an "Updated Notice of Acceptance at Closure," under OAR 436-030-0015(1)(e)(D), the insurer must add the word "Corrected" to the notice.

(B) An "Updated Notice of Acceptance at Closure" is not necessary to begin payment of benefits following a worker's death during a period of permanent total disability under OAR 436-060-0075(7).

(c) An insurer must issue a "Modified Notice of Acceptance" (MNOA) when the insurer:

(A) Accepts a new or omitted condition on a nondisabling claim, while a disabling claim is open or after claim closure;

(B) Accepts an aggravation claim;

(C) Changes the disabling status of the claim; or

(D) Amends a notice of acceptance, including correcting a clerical error, except for an error or omission on an "Updated Notice of Acceptance at Closure."

**(7) Acceptance of new or omitted conditions.**

When an insurer accepts a new or omitted condition on a closed claim, the insurer must reopen the claim and process it to closure under ORS 656.262 and 656.267. When a claim is reopened, the notice of acceptance must specify the conditions for which the claim is being reopened.

**(8) Notice of denial to worker.**

A notice of denial must comply with OAR chapter 438 and the following, and must:

(a) The notice must Specify-specify the factual and legal reasons for the denial, including the worker's right to request a worker requested medical examination and a specific statement indicating if the denial was based in whole or part on an independent medical examination; under ORS 656.325;

(b) If the denial was based in whole or part on an independent medical examination under ORS 656.325:

(A) The notice must include-and one of the following statements, as appropriate.:

(Ai) "Your attending physician agreed with the independent medical examination

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report”;

(~~Bii~~) “Your attending physician did not agree with the independent medical examination report”; or

(~~Ciii~~) “Your attending physician has not commented on the independent medical examination report”; and

(B) If subparagraph (8)(b)(A)(ii) or (iii) of this rule apply, the notice must include the division’s website address and toll free phone number for the worker’s use in obtaining a brochure about the worker requested medical examination.

(~~bc~~) The notice must ~~in~~form the worker of the Expedited Claim Service and of the worker’s right to a hearing under ORS 656.283; and

(~~ed~~) If the denial is under ORS 656.262(15), ~~it~~ the notice must inform the worker that a hearing may occur sooner if the worker requests an expedited hearing under ORS 656.291; and.

~~(d) If paragraph (8)(a)(B) of this rule applies, the denial notice must also include the division’s website address and toll free phone number for the worker’s use in obtaining a brochure about the worker requested medical examination.~~

**(9) Notice of denial to provider of medical services and health insurance.**

The insurer must send notice of the denial to each medical service provider ~~of medical services~~, and provider of health insurance as defined under ORS 731.162; when compensability of any portion of a claim for medical services is denied. The notice must be sent: when any of the following applies:

- (a) At the same time ~~The~~ ~~the~~ denial is sent to the worker;
- (b) Within 14 days of receipt of any billings from medical providers not previously notified of the denial. The notice must advise the medical provider of the status of the denial; or
- (c) Within 60 days of the date when compensability of the claim has been finally determined or when disposition of the claim has been made. The notification must include the results of the proceedings under ORS 656.236 or 656.289(4) and the amount of any settlement.

**(10) Payment of compensation.**

The insurer must pay compensation due under ORS 656.262 and 656.273 until the claim is denied, except where there is an issue concerning the timely filing of a notice of accident as provided in ORS 656.265(4). The employer may elect to pay compensation under this section in lieu of the insurer doing so. The insurer must report to the division payments of compensation made by the employer as if the insurer had made the payment.

**(11) Medical benefits and funeral expenses.**

Compensation payable to a worker or the worker’s beneficiaries while a claim is pending acceptance or denial does not include:

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- (a) The costs of medical benefits; or
- (b) The cost of final disposition of the body or funeral expenses.

Statutory authority: ORS 656.726(4)  
Statutes implemented: ORS 656.262, 656.325, and 656.726(4)  
Hist: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010  
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17  
[Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18](#)  
See also the Index to Rule History: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

**436-060-0147 Worker Requested Medical Examination**

**(1) Eligibility.**

~~The director will determine the worker's eligibility for a worker requested medical examination under ORS 656.325(1).~~ The worker is eligible for an [worker requested medical examination under ORS 656.325\(1\)\(e\)](#) exam if:

- (a) The worker has made a timely request for a Workers' Compensation Board hearing on a denial of compensability ~~as required by ORS 656.319(1)(a)~~;
- (b) The denial ~~was is~~ based on one or more independent medical examination reports; and
- (c) The attending physician or authorized nurse practitioner ~~did does~~ not concur with the report or reports.

**(2) Request for exam.**

The worker must submit a request for the exam to the division. A copy of the request must be sent simultaneously to the insurer.

[\(a\)](#) The request must include:

- [\(aA\)](#) The name, address, and claim identifying information of the worker;
- [\(bB\)](#) A list of physicians, including names and addresses, who have previously provided medical services to the worker on the claim, or who have previously provided medical services to the worker related to the claimed conditions;
- [\(cC\)](#) The date the worker requested a hearing and a copy of the hearing request;
- [\(dD\)](#) A copy of the insurer's denial letter; and
- [\(eE\)](#) Documents that demonstrate that the attending physician or authorized nurse practitioner ~~did does~~ not concur with the independent medical examination report or reports, [if available](#).

[\(b\)](#) The director will determine the worker is eligible for an exam if:

- [\(A\)](#) The worker or insurer provides documents that demonstrate that the attending physician or authorized nurse practitioner does not concur with the independent medical examination report or reports; or
- [\(B\)](#) The director has not received documents that demonstrate the attending physician or authorized nurse practitioner does or does not concur with the report or reports,

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[and at least 30 days after the worker's request for hearing under subsection \(1\)\(a\) of this rule have passed.](#)

**(3) Required documentation.**

The insurer must mail to the director no later than the 14th day following the insurer's receipt of the worker's request, the names and addresses of all physicians or nurse practitioners who have:

- (a) Acted as the worker's attending physician or authorized nurse practitioner;
- (b) Provided medical consultations or treatment to the worker;
- (c) Examined the worker at an independent medical examination requested by the insurer under ORS 656.325; or
- (d) Reviewed the worker's medical records on the claim.

**(4) Penalty for failure to provide documentation.**

Failure to provide the required documentation described in section (3) of this rule in a timely manner may subject the insurer to civil penalties under OAR 436-060-0200.

**(5) Selection of physicians.**

[If the director determines the worker is eligible for the exam,](#) ~~The-the~~ director will notify all parties in writing of the physician selected, or will provide the worker or the worker's attorney a list of appropriate physicians. If the director provides a list of physicians, the following applies:

- (a) The worker's or the worker's attorney's response must be in writing, signed, and delivered to the director within 14 days of the mailing date of the list;
- (b) The worker or the worker's attorney may eliminate the name of one physician from the list;
- (c) If the worker or the worker's attorney does not respond as provided in this section, the director will select a physician; and
- (d) The director will notify the parties in writing of the physician selected.

**(6) Scheduling the exam.**

The worker or the worker's attorney must schedule the exam with the selected physician, and notify the insurer and the Workers' Compensation Board of the scheduled exam date within 14 days of the [date of the director's notice](#) ~~notification date~~ in section (5) of this rule. [The exam is not required to take place within the 14-day notification period.](#) An unrepresented worker may consult with the Ombudsman for Injured Workers for assistance.

**(7) Required medical records.**

The insurer must send the physician the worker's complete medical and diagnostic record on the claim and the original questions asked of the independent medical examination physicians no later than 14 days before the date of the scheduled exam. If the diagnostic records are not in the insurer's possession, the insurer must request that the medical provider

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send the diagnostic records to the selected physician at least 14 days before the scheduled exam.

**(8) Exam questions.**

The worker, or the worker's attorney, must communicate questions related to the compensability denial in writing to be answered by the physician at the exam to the physician at least 14 days before the scheduled date of the exam. An unrepresented worker may consult with the Ombudsman for Injured Workers for assistance.

**(9) Physician's response.**

Upon completion of the exam the physician must address the original independent medical examination questions and the questions from the worker or the worker's attorney under section (8) of this rule and send the report to the worker's attorney, if any, or the worker, and the insurer within 14 days.

**(10) Payment of physician.**

The insurer must pay the physician selected under this rule in accordance with OAR 436-009. Medical services to workers must be delivered in accordance with OAR 436-010.

**(11) Failure to attend exam.**

If the worker does not attend the scheduled worker requested medical exam, the insurer must pay the physician for the missed exam under OAR 436-009-0010(13). The insurer is not required to pay for another exam unless the worker did not attend the missed examination for reasons beyond the worker's reasonable control.

**(12) Reimbursement for services.**

The insurer must reimburse the worker for all necessary related services under ORS 656.325(1).

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.325(1)

Hist: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010

Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17

[Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18](#)

See also the Index to Rule History: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

**436-060-0150 Timely Payment of Compensation**

**(1) General.**

Benefits are considered paid when addressed to the last known address of the worker or beneficiary and deposited in the U.S. Mail, or when funds are transferred to a financial institution for deposit in the worker's or beneficiary's account by approved electronic equivalent. Payments due on a weekend or legal holiday under ORS 187.010 and 187.020 may be paid on the last working day before, or the first working day after, the weekend or legal holiday. Subsequent payments may revert back to the payment schedule in place before the weekend or legal holiday.

**(2) Holidays.**

For the purpose of this rule, legal holidays in the State of Oregon are:

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- (a) Each Sunday;
- (b) New Year's Day on January 1;
- (c) Martin Luther King, Jr.'s Birthday on the third Monday in January;
- (d) Presidents Day, for the purpose of commemorating Presidents Washington and Lincoln, on the third Monday in February;
- (e) Memorial Day on the last Monday in May;
- (f) Independence Day on July 4;
- (g) Labor Day on the first Monday in September;
- (h) Veterans Day on November 11;
- (i) Thanksgiving Day on the fourth Thursday in November;
- (j) Christmas Day on December 25.
- (k) Each time a holiday, other than Sunday, falls on Sunday, the succeeding Monday;
- (l) Each time a holiday falls on Saturday, the preceding Friday; and
- (m) Every day appointed by the Governor as a legal holiday and every day appointed by the President of the United States as a day of mourning, rejoicing or other special observance only when the Governor also appoints that day as a holiday.

**(3) Withheld compensation.**

Compensation withheld under ORS 656.268(13) and (14), and ORS 656.596(2), will not be considered late if the insurer notifies the worker in writing why benefits are being withheld and the amount that must be offset before any further benefits are payable.

**(4) Timely payment of temporary disability.**

First payment of temporary disability compensation must be timely. The director may assess a penalty under OAR 436-060-0200 against an insurer that does not make the first payment of temporary disability under the time frames of this section, or does not accurately report timeliness of first payment information.

- (a) The first payment of temporary disability benefits must be made no later than the 14th day after:
  - (A) The date of the employer's notice or knowledge of the claim and of the worker's disability, if the attending physician or authorized nurse practitioner has authorized temporary disability compensation. Temporary disability accrued before the date of the employer's notice or knowledge of the claim is due within 14 days of claim acceptance;
  - (B) The date the attending physician or authorized nurse practitioner authorizes temporary disability, if the authorization is more than 14 days after the date of the employer's notice or knowledge of the claim and of the worker's disability;

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- (C) The start of authorized vocational training under ORS 656.268(10), if the insurer has previously closed the claim;
  - (D) The date the insurer receives medical evidence supported by objective findings that shows the worker is unable to work due to a worsening of the compensable condition under ORS 656.273;
  - (E) The date of any director's order, including, but not limited to, a reconsideration order, that orders payment of temporary disability. If the insurer has appealed a reconsideration order, the appeal stays payment of temporary disability benefits except those that accrue from the date of the order, under ORS 656.313;
  - (F) The date of a notice of claim closure issued by the insurer that finds the worker entitled to temporary disability;
  - (G) The date a notice of closure is set aside by a reconsideration order;
  - (H) The date any litigation authorizing retroactive temporary disability becomes final. Temporary disability accruing from the date of the order must begin no later than the 14th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board is the signature date, and from the courts, it is the date of the appellate judgment;
  - (I) The date the director refers a claim to the insurer for processing under ORS 656.029;
  - (J) The date the director refers a noncomplying employer claim to an assigned claims agent under ORS 656.054;
  - (K) The date a claim disposition agreement is disapproved by the Worker's Compensation Board or administrative law judge, if temporary disability benefits are otherwise due;
  - (L) The date the director designates a paying agent under ORS 656.307;
  - (M) The date a claim is reclassified from nondisabling to disabling, if temporary disability is due and payable; or
  - (N) The date an insurer voluntarily rescinds a denial of a disabling claim.
- (b) Subsequent payments of temporary disability benefits must:
- (A) Be made at least once each 14 days, unless the employer is making payments under OAR 436-060-0020(1) and the payments are made concurrently with the payroll schedule of the employer; and
  - (B) Include all benefits due for the period ending no more than seven days before the payment date;
- (5) Timely payment of permanent disability.**
- (a) The first payment of permanent disability must be paid no later than the 30th day after:

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- (A) The date of a notice of claim closure issued by the insurer;
  - (B) The date of any litigation order that orders payment of permanent total disability. Permanent total disability benefits accruing from the date of the order must begin no later than the 30th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board is the signature date, and from the courts, it is the date of the appellate judgment;
  - (C) The date of any director's order, including, but not limited to, a reconsideration order, that orders payment of compensation for permanent disability;
  - (D) The date any litigation order authorizing permanent partial disability becomes final;
  - (E) The date a claim disposition agreement is disapproved by the Workers' Compensation Board or administrative law judge, if permanent disability benefits are otherwise due; or
  - (F) The date authorized training ends if the worker is medically stationary and any previous award remains unpaid, under ORS 656.268(10) and OAR 436-060-0040(3).
- (b) Subsequent payments of permanent disability must be made on a regular and predictable monthly schedule.
- (A) The insurer may adjust the monthly payment schedule, but must inform the worker or beneficiary before making the adjustment.
  - (B) No payment period may exceed one month without the director's approval.

**(6) Timely payment of ~~fatal-death~~ benefits.**

(a) Payment of bills submitted under OAR 436-060-0075(1) must be made no later than the 30th day after the date of the insurer's receipt the bill, or the date of claim acceptance, whichever is later.

(ab) The first payment of ~~fatal-monthly~~ benefits to eligible beneficiaries under ~~ORS 656.204~~OAR 436-060-0075 must be paid no later than the 30th day after:

- (A) The date of a notice of acceptance issued by the insurer; or
- (B) The date of any litigation order which orders ~~fatal-death~~ benefits. ~~Fatal-Death~~ benefits accruing from the date of the order must begin no later than the 30th day after:

- (i) The signature date of an order from the Workers' Compensation Board; or
- (ii) The date of an appellate judgement from the courts. ~~the date the order is filed.~~ For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board is the signature date, and from the courts, it is the date of the appellate judgment.

(bc) Subsequent payments of ~~fatal-monthly~~ benefits to eligible beneficiaries under OAR 436-060-0075 must be made on a regular and predictable ~~monthly~~-schedule, subject to the following:-

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(A) The insurer may adjust the monthly payment schedule, but must inform the beneficiary before making the adjustment; and

;

(B) No payment period may exceed one month without the director's approval.

(d) Notwithstanding subsection (c), the insurer may make a payment in advance with the consent of the beneficiary.

(e) Payment of monthly benefits due to a worker's death during a period of permanent total disability under OAR 436-060-0075(7) must follow the monthly schedule established under subsection (5)(b) of this rule.

**(7) Notice to worker or beneficiary regarding payments.**

The insurer must provide an explanation in writing to the worker or beneficiary when the benefit amount, time period covered, or payment schedule changes, and must:

(a) Notify the worker or beneficiary in writing of the specific purpose and the time period covered by each payment of temporary disability benefits; and

(b) Notify the worker or beneficiary in writing of the specific purpose of the payment, the schedule of future payments, and the time period each payment will cover with the first payment of permanent disability or ~~fatal-death~~ benefits. The insurer is not required to provide an explanation in writing with each subsequent permanent disability or ~~fatal death~~ benefit payment.

**(8) Maintenance of records.**

The insurer must maintain records of compensation paid for each claim in which benefits are due and payable.

**(9) Request for reimbursement.**

If the worker submits a request for reimbursement of multiple items and full reimbursement is not made, the insurer must provide specific reasons for non-payment or reduction of each item.

**(10) Claim disposition agreements.**

Any amounts due under a claim disposition agreement must be paid no later than the 14th day after the Workers' Compensation Board or administrative law judge provides notice of its approval under OAR 438-009-0028, unless otherwise stated in the agreement.

**(11) Claims under other jurisdictions.**

When a worker has a claim under the workers' compensation law of another state, territory, province or foreign nation for the same injury or occupational disease as the claim filed in Oregon:

(a) The worker is entitled to the full amount of compensation due under Oregon law;

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- (b) The total amount paid or awarded under the other jurisdiction's law must be credited against the compensation due under Oregon law;
- (c) If Oregon compensation is more than the compensation paid or awarded under the other jurisdiction's law, or compensation paid the worker under another law is recovered from the worker, the insurer must pay any unpaid compensation to the worker up to the amount required by the claim under Oregon law;
- (d) Upon learning that the worker has a claim under the jurisdiction of another workers' compensation law, the insurer must request written documentation of the amount paid or awarded to the worker; and
- (e) Payment under this section is due within 14 days of receipt of written documentation supporting the underpayment of Oregon compensation.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.126, 656.262(4), 656.268(10), 656.273, 656.278, 656.289, 656.307, and 656.313

Hist: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16

Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17

[Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18](#)

See also the Index to Rule History: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

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# Retroactive Program Oregon Administrative Rules Chapter 436, Division 075

*Proposed*

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**NOTE:** Revisions are marked as follows: new text | ~~deleted text~~.

**Historical rules:** [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf)

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*Proposed RETROACTIVE PROGRAM*

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**OREGON ADMINISTRATIVE RULES**  
**CHAPTER 436, DIVISION 075**

**436-075-0001** — **Authority for Rules**

~~These rules are promulgated under the director's authority in ORS 656.726 and 656.506.~~

~~Statutory authority: ORS 656.506 and 656.726  
Statutes implemented: ORS 656.506  
Hist: Filed 12-22-89 as WCD Admin. Order 6-1989, eff. 1-1-1990  
Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16  
Repealed xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18~~

**436-075-0002** — **Purpose**

~~The purpose of these rules is to establish guidelines for administering disbursements made from the Retroactive Program.~~

~~Statutory authority: ORS 656.506  
Statutes implemented: ORS 656.506  
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98  
Repealed xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18~~

**436-075-0003**      **Applicability of Rules**

(1) These rules ~~are effective January 1, 2016, and~~ apply to all requests for reimbursement from the Retroactive Program involving benefits payable under:

- (a) ORS 656.204 Death;
- (b) ORS 656.206 Permanent Total Disability;
- (c) ORS 656.208 Death During Permanent Total Disability; and
- (d) ORS 656.210 Temporary Total Disability for injuries before April 1, 1974.

(2) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

~~Statutory authority: ORS 656.209, 656.206, 656.208, 656.210, 656.236, 656.289 and 656.506, 656.726(4)  
Statutes implemented: ORS 656.204, 656.206, 656.208, 656.209, 656.210, 656.236, 656.276, 656.289, and 656.506  
Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98  
Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16  
Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18  
See also the *Index to Rule History*: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).~~

**436-075-0005**      **Definitions**

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made a part of these rules. Except whereFor the purposes of these rules, unless the context requires otherwise, ~~these rules are governed by the following definitions:~~

~~(1) "Beneficiaries" are those persons as defined in ORS 656.005.~~

(2) "Child" is as defined in the laws ORS chapter 656 applicable at the worker's date of injury.

(3) "Department" means the Department of Consumer and Business Services.

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(43) "Director" means the director of the Department of Consumer and Business Services or the director's designee.

~~(5) "Disposition" or "claim disposition" means the written agreement executed by all parties in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794, except for medical services, in an accepted claim.~~

(64) "Insurer" means the State Accident Insurance Fund Corporation, an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state, or an employer or employer group that has been certified as self-insured under ORS 656.430.

~~(7) "Performance Section" means the Performance Section of the Workers' Compensation Division of the Department of Consumer and Business Services.~~

(5) "Mailed" or "mailing date," unless otherwise specified, means:

(a) The date a document is postmarked;

(b) The date automatically produced by electronic transmission (e.g., email or facsimile);

(c) The date a hand-delivered document is stamped or punched in by the recipient; or

(d) The date of a phone, or in-person request, when allowed under these rules.

(86) "Retroactive Program benefit" means ~~that the~~ additional benefit amount paid to eligible claimants ~~an eligible worker~~ or beneficiaries ~~beneficiary to bring when their~~ benefits levels are lower than what is to a more currently paid for like injuries ~~level~~.

~~(9) "Social Security offset" means a reduction of permanent total disability benefits or fatal benefits based on the amount of federal social security disability benefits received by a worker or surviving spouse.~~

~~(107) "Spouse" means the spouse of a worker. This definition~~ includes cohabitants under ORS 656.226.

~~(118) "Statutory benefit" means any benefit payable to or on behalf of the injured worker under the law in effect at the time of the worker's injury, as modified by marital and dependency status changes.~~

~~(12) "Through" means inclusion of a specific date.~~

~~(13) "To" means until but not including a specific date.~~

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.726(4)

Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98

Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16

Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18

See also the *Index to Rule History*: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

#### **436-075-0006 — Administration of Rules**

~~In administering these rules, orders of the Performance Section are deemed orders of the director.~~

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Statutory authority: ~~ORS 656.726~~  
 Statutes implemented: ~~ORS 656.726~~  
 Hist: Filed 12-22-89 as WCD Admin. Order 6-1989, eff. 1-1-90  
 Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16  
 Repealed xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18

**436-075-0008 Administrative Review**

(1) Any party ~~as defined by ORS 656.005~~ aggrieved by a proposed order or proposed assessment of civil penalty ~~of the director or division~~ issued under ORS 656.745 or 656.750 may request a hearing by the Hearings Division of the Workers' Compensation Board under ORS 656.740. To request a hearing the party, or assigned claims agent, must:

~~(a) The request for hearing must be sent in writing to the Administrator of the Workers' Compensation Division. No hearing will be granted unless the request specifies the grounds on which the person requesting the hearing contests the proposed order or assessment.~~

(a) Mail or deliver a written request for hearing to the Workers' Compensation Division within 60 days of the mailing date of the proposed order or assessment; and

~~(b) The request for hearing must be filed with the Administrator of the Workers' Compensation Division by the aggrieved person within 60 days after the mailing of the proposed order or assessment. No hearing will be granted unless the request is mailed or delivered to the administrator within 60 days after the mailing date of the proposed order or assessment.~~

(b) Specify the reasons why the party or assigned claims agent disagrees with the proposed order or assessment in the request.

(2) ~~Under ORS 656.704(2), a~~Any party that disagrees with an action or order of the director under these rules, other than as described in section (1) of this rule, may request a hearing by filing a request for hearing under OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Statutory authority: ORS ~~656.726(4)~~656.740, ~~656.745, 656.750~~  
 Statutes implemented: ORS 656.704, ~~OL 2005 ch 26~~, 656.740, 656.745, ~~and~~ 656.750  
 Hist: Amended 10/19/05 as WCD Admin. Order 05-065, eff. 1/2/06  
 Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16  
 Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18  
 See also the *Index to Rule History*: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

**436-075-0010 Criteria for Eligibility**

(1) The department will issue a bulletin to notify all insurers of changes in the Retroactive Program benefit levels whenever the director determines a change is necessary under ORS 656.506(7).

(2) Eligibility for Retroactive Program benefits is based on the worker's injury date as follows:

(a) Workers or beneficiaries eligible to receive either death or permanent total disability benefits become eligible for Retroactive Program benefit increases when the benefits granted under the Retroactive Program bulletin exceed the benefits provided by the statute in effect at the time of the injury.

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(b) ~~For workers~~ Workers receiving temporary total disability benefits, are eligible for Retroactive Program benefit increases as follows:

(A) Workers with the injuries must have occurred-occurring before July 1, 1973 are eligible for Retroactive Program benefit increases:-

(B) Workers with injuries occurring between-from July 1, 1973 and-through April 1, 1974 may qualify-be eligible for benefits according to the limits defined in the Retroactive Program bulletin; and-

(C) Workers with injured-injuries occurring on or after April 1, 1974 are not entitled eligible to receive Retroactive Program increases to their temporary total disability benefit.

(3) A claim is not eligible for Retroactive Program benefits if all issues except compensable medical services are disposed of under ORS 656.236 or settled under ORS 656.289 before becoming eligible under section (2) of this rule.

(4) Costs for claims of subject workers of a noncomplying employer under ORS 656.052 are not eligible for reimbursement from the program, but remain a cost recoverable from the employer under ORS 656.054(23).

Statutory authority: ORS 656.506, 656.726(4)

Statutes implemented: ORS 656.236, 656.289, ~~and~~ 656.506

Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98

Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16

Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18

See also the *Index to Rule History*: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

#### **436-075-0020      Death Benefit**

(1) Death benefits must be paid to eligible beneficiaries under ORS 656.204, OAR 436-060-0075, and the benefit schedules in the Retroactive Program benefit schedules bulletin.

~~(2) Burial benefits must be paid under ORS 656.204 (1) and the Retroactive Program benefit schedules.~~

~~(3)~~ The statutory death benefit for injuries occurring from July 1, 1973 ~~to-through~~ April 1, 1974 will be reduced by the Social Security benefits received by the worker's surviving spouse, ~~up to not to exceed~~ the July 1, 1973 statutory benefit level. The amount of reduction to the statutory benefit is a Retroactive Program benefit. The insurer may request reimbursement only for the adjusted Retroactive Program benefit.

~~(4) Benefits payable for a partial month must be calculated by dividing the monthly benefit by the actual number of days in the month and multiplying that result by the number of days payable.~~

~~(5) Benefits for beneficiaries must be paid to the date of any status change.~~

~~(6) Remarriage allowance must be paid under ORS 656.204 and the Retroactive Program benefit schedules.~~

~~(7)~~ At least once every two years, the insurer must verify that all beneficiaries receiving death benefits for which the insurer may request reimbursement from the Retroactive Program are alive and remain eligible for those benefits. Insurers' questions regarding

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beneficiaries' status must be reasonably pertinent to the continuing eligibility of those persons for benefits.

Statutory authority: ORS 656.506, [656.726\(4\)](#)  
 Statutes implemented: ORS 656.204, [656.506](#)  
 Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98  
 Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16  
[Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18](#)  
 See also the *Index to Rule History*: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

**436-075-0030 Permanent Total Disability Benefit**

(1) Permanent total disability benefits must be paid under ORS 656.206 and the benefit schedules in the Retroactive Program bulletin.

(2) [Benefits payable for a partial month must be calculated by dividing the monthly benefit by the actual number of days in the month and multiplying that result by the number of days payable.](#)

~~Benefit amounts payable for a partial month must be calculated under 436-075-0020(4).~~

(3) Benefits for beneficiaries must be paid to the date of any status change.

(4) Any Social Security offset determined under ORS 656.209 must first be applied against the statutory portion of the permanent total disability benefit. Any amount of the Social Security offset that exceeds the statutory benefit must be applied against the Retroactive Program benefit. The insurer may request reimbursement only for that portion of the Retroactive Program benefit that has not been offset.

(5) At least once every two years, the insurer must verify that all beneficiaries receiving benefits for which the insurer may request reimbursement from the Retroactive Program are alive and remain eligible for those benefits. Such "status checks" of beneficiaries may occur at the same time the insurer re-examines the permanent total disability claim under OAR 436-030-0065(1). Insurers' questions regarding beneficiaries' status must be reasonably pertinent to the continuing eligibility of those persons for benefits.

Statutory authority: ORS 656.506, [656.726\(4\)](#)  
 Statutes implemented: ORS 656.206, ~~and~~ 656.209, [656.506](#)  
 Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98  
 Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16  
[Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18](#)  
 See also the *Index to Rule History*: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

**436-075-0040 Death during Permanent Total Disability**

(1) If the injured worker dies during the period of permanent total disability, death benefits must be paid to eligible beneficiaries under ORS 656.208, 656.204, [OAR 436-060-0075](#), and the [benefit schedules in the](#) Retroactive Program [benefit schedules](#) bulletin.

~~(2) Permanent total disability benefits must be paid to the date of death, at which time death benefits will begin. Where death benefits are not due, permanent total disability benefits must be paid through the date of death.~~

~~(3) The statutory death benefit for injuries occurring from July 1, 1973 to April 1, 1974 will be reduced by the Social Security benefits received by the worker or the worker's surviving spouse, not to exceed the July 1, 1973 statutory benefit level. The amount of reduction to the~~

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statutory benefit is a Retroactive Program benefit. The insurer may request reimbursement only for the adjusted Retroactive Program benefit.

~~The Social Security benefit for injuries occurring between July 1, 1973 and April 1, 1974 must be applied under OAR 436-075-0020(3).~~

~~(4) Benefit amounts payable for a partial month must be calculated under OAR 436-075-0020(4).~~

~~(5) Burial benefits must be paid under ORS 656.208 (1), 656.204 (1), and the Retroactive Program benefit schedules. However, if the injury date is before July 1, 1973, burial benefits are due only if death results from the accidental injury causing the permanent total disability.~~

(63) At least once every two years, the insurer must verify that all beneficiaries receiving death benefits for which the insurer may request reimbursement from the Retroactive Program are alive and remain eligible for those benefits. Insurers' questions regarding beneficiaries' status must be reasonably pertinent to the continuing eligibility of those persons for benefits.

Statutory authority: ORS 656.506, [656.726\(4\)](#)  
 Statutes implemented: ORS 656.204, ~~and~~ 656.208, [656.506](#)  
 Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98  
 Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16  
 Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18  
 See also the *Index to Rule History*: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

#### **436-075-0050 Temporary Total Disability**

(1) Temporary total disability benefits must be paid under ORS 656.210, OAR 436-060-0150, and the benefit schedules in the Retroactive Program bulletin.

(2) The computation of benefits under these rules and the Retroactive Program bulletin may not reduce temporary total disability benefits currently being paid.

Statutory authority: ORS 656.506  
 Statutes implemented: ORS 656.210  
 Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98  
 Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16  
 See also the *Index to Rule History*: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

#### **436-075-0065 Dispositions**

(1) ~~Any Disposition-disposition~~ of the claim by the parties under ORS 656.236, or settlement of the claim under ORS 656.289, is not eligible for reimbursement from the Retroactive Program unless it is approved by made with the director's prior written approval before it is submitted to the Workers' Compensation Board.

(2) Requests for ~~written the director's~~ approval of proposed dispositions must be made in writing, and must include:

- (a) A copy of the proposed disposition that specifies the amount of the proposed contribution to be made from the Retroactive Program;
- (b) A statement from the insurer indicating how the amount of the contribution was calculated; and
- (c) Any other information required by the director.

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- (3) The director will not approve the disposition ~~for reimbursement~~ if:
- (a) The ratio of the amount requested from the program to the total amount of the disposition exceeds the percentage of current benefits due the worker from the program;  
or
  - (b) The settlement exceeds a reasonable projection of future liability.
- (4) The insurer must submit dispositions to the Workers' Compensation Division in the format prescribed by the director.

Statutory authority: ORS 656.506, 656.726(4)  
 Statutes implemented: ORS 656.236, ~~and~~ 656.289  
 Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98  
 Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16  
Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18  
 See also the *Index to Rule History*: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

#### **436-075-0070 Reimbursement**

- (1) Reimbursement from the Retroactive Program will be authorized by the Performance Section Workers' Compensation Division on a quarterly basis.
- (2) Requests for reimbursement must be mailed or delivered to the Performance Section Workers' Compensation Division within 30 days after the end of each calendar quarter to be processed in that quarterly disbursement.
- (3) Requests for reimbursement mailed or delivered to the Performance Section Workers' Compensation Division more than 30 days after the end of the quarter will be ~~processed~~ with the next quarterly disbursement.
- (4) A separate request for reimbursement must be submitted for each insurer and ~~include~~ a signed certification that the payments reported on the request have been made in the amounts reported.
- (5) The insurer must use Form 3285, "Requests for Reimbursement from the Retroactive Program," must be submitted in the format prescribed by the director or an equivalent form, to request reimbursement from the Retroactive Program.
- (a) If an equivalent form is used, it must include all of the data elements on Form 3285; and
  - (b) Each request must accurately reflect the marital and dependency status in effect and eligible for reimbursement in the period requested.
- (6) The ~~Performance Section~~ director will not process any request that does not meet the requirements of section (4) ~~or and~~ (5) of this rule. ~~until such requirements are met.~~
- (7) The department will recover any overpayment made to an insurer as a result of an insurer reporting error ~~in reporting~~, or incorrect information submitted, on a quarterly request form.
- (8) If a denied claim is found to be compensable by an administrative law judge, the Workers' Compensation Board, or the Court of Appeals, and that decision is subsequently reversed by a higher level of appeal, the insurer will receive reimbursement for Retroactive Program benefit payments required to be made while the claim was in an accepted status.

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Statutory authority: ORS 656.506, [656.726\(4\)](#)  
 Statutes implemented: ORS 656.506  
 Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98  
 Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16  
[Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18](#)  
 See also the *Index to Rule History*: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

**436-075-0090 Third Party Recovery**

- (1) In a third party recovery, previously reimbursed Retroactive Program benefits are a portion of the paying agency's lien.
- (2) ~~Under ORS 656.593, w~~When the insurer learns of third-party settlement negotiations on any claim for which it has received reimbursement from the Retroactive Program, the insurer must notify the ~~Performance Section~~[Workers' Compensation Division](#).
- (3) ~~The insurer must make Remittance~~remittance on recovered Retroactive Program benefits ~~must be made~~ to the department in the quarter following the recovery in amounts determined under ORS 656.591 and 656.593.

Statutory authority: ORS 656.506, [656.726\(4\)](#)  
 Statutes implemented: ORS [656.506](#), 656.591, ~~and~~ 656.593  
 Hist: Amended 12/4/97 as WCD Admin. Order 97-062, eff. 1/1/98  
 Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16  
[Amended xx/xx/xx as WCD Admin. Order 17-XXX, eff. 1/1/18](#)  
 See also the *Index to Rule History*: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).

**436-075-0100 Assessment of Civil Penalties**

Under ORS 656.745 the director may assess a civil penalty against an insurer for failure to comply with these rules. Penalty orders will be issued under ORS 656.447 and 656.704 and are subject to review under OAR 436-075-0008.

Statutory authority: ORS 656.745  
 Statutes implemented: ORS 656.204, 656.726, 656.745 and 656.447  
 Hist: Amended 11-29-90 as WCD Admin. Order 23-1990, eff. 12-26-90  
 Amended 10/12/15 as WCD Admin. Order 15-063, eff. 1/1/16  
 See also the *Index to Rule History*: [http://wcd.oregon.gov/laws/Documents/Rule\\_history/436\\_history.pdf](http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf).