Oregon Administrative Rule Revision
Chapter 436, Division 60

Meeting Minutes
Rules Advisory Committee Meeting
January 25, 2024

Location of meeting: 350 Winter St. NE, Salem, OR; Virtual Teams meeting

Stakeholders attending:

Stakeholders (RSVP'd):	
Amber McMurry	Multnomah County
Abby Smith	CorVel Corporation
Amy Stone	TRISTAR Risk Management
Catherine Shaw	Sedgwick
Connie Whelchel	KPD Insurance
Deanna Judd	City of Springfield
Elaine Schooler	SAIF
Gina Wescott	Special Districts Association of Oregon (SDAO)
Kirsten Adams	Associated General Contractors
Lourdes Alvarez	Amy's Kitchen
Michelle Cross	Multnomah County
Steven Bennett	American Property Casualty Insurance Association
Thais Lomax	Sedgwick
Drew Lindsey	IBEW 280
Keith Semple	Oregon Trial Lawyers Association
Jovanna Patrick	Oregon Trial Lawyers Association
Tanya Miller	CCMSI
Kevin Anderson	SBH Legal
Josh Carter	IBEW 48
Julie Riddle	Enterprise Compliance
Ivo Trummer	SAIF
Joe Silva	SAIF
Eric Boling	TRISTAR
Jennifer Hurtado	Safeway
Susan Lavier	TriMet
Kevin Barrett	SAIF
Chi Nguyen	Safeway
Diana Johnson	GBTPA
Virginia Jones	Strategic Comp
Lauren Rolater	Farmers Insurance

Department staff members attending:

Matt West
Adam Breitenstein
Barb Belcher
Troy Painter
Teri Watson
Stanley Fields
Marie Rogers (Loiseau)
Summer Tucker
Juerg Kunz
Michael Fevurly
Barbra Anderson
Maria Venegas

Minutes: Marie Rogers (Loiseau) welcomed the committee members, asked the members to provide advice about any fiscal impacts of possible rule changes, and also to advise about effects on racial equity in Oregon. Marie called a roll of attendees, including stakeholders and State of Oregon employees.

NOTE: Additional summary minutes are included below each issue.

Issue 1

Rule: OAR 436-060-0015(7) Notice of end of temporary disability benefits

Issue: Senate Bill 418 (2023) adds an exemption to the notice requirement in ORS 656.262(4)(j)(A) and OAR 436-060-0015(7). This exemption is currently not noted in the rule.

Background:
House Bill 4138 (2022) added a requirement to Oregon workers' compensation law (ORS 656.262(4)(j)(A)) that the insurer or self-insured employer may not end temporary disability benefits until written notice has been mailed or delivered to the worker and the worker's attorney, if the worker is represented. Following the 2022 legislative session, but before the introduction of Senate Bill 418 (2023), the division conducted rulemaking and added the notice requirement to OAR 436-060-0015, effective Jan. 1, 2024.

Senate Bill 418 (2023) specified that the House Bill 4138 notice requirement does not apply to temporary disability benefits paid under ORS 656.210(4) (temporary disability paid for medical appointment absences). Senate Bill 418 became effective on Jan. 1, 2024. However, OAR 436-060-0015(7) currently does not mention this exemption. To ensure insurers are aware there is an exemption to the notice requirement, the division believes it may be beneficial to clarify the rule.

Options
1) Amend OAR 436-060-0015(7) as follows:

   (7) Notice of end of temporary disability benefits.
   In addition to other requirements in OAR chapter 436, the insurer may not end temporary disability benefits until written notice has been mailed or delivered to the worker and the worker's attorney, if the worker is represented. The notice must state the reason that temporary disability benefits are no longer due and payable. This notice requirement does not apply to temporary disability benefits paid under ORS 656.210(4).

2) No changes.
3) Other.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:
Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Julie Riddle requested that the division add a tagline briefly identifying the statute referenced in the proposed language.
- Drew Lindsey requested clarification regarding the duration of temporary disability.
- Summer Tucker clarified that there is no specific limit on the duration of temporary disability.

- Lauren Rolater requested clarification regarding the notice insurers must provide before ending benefits; Lauren asked how much notice needs to be given.
- Summer Tucker stated that this rule does not provide a particular amount of time that notice must be provided before terminating benefits.
- Thais Lomax reiterated Julie Riddle's request for a tagline regarding the statute.

Issue 2

Rule: OAR 436-060-0155(4) Jurisdiction over proceedings

Issue: The rule requires referring penalty issues to the Workers' Compensation Board (Board) if proceedings have been initiated at the Board. However, in some cases, referral to the Board is not necessary or appropriate.

Background:
Under ORS 656.262(11)(a) and OAR 436-060-0155(1), the director may require the insurer to pay a penalty to the worker, and a fee to the worker's attorney, if the insurer:

- Unreasonably delays or unreasonably refuses to pay compensation, attorney fees or costs.
- Unreasonably delays acceptance or denial of a claim.

The rule states that the director has exclusive jurisdiction when the assessment and payment of this penalty and attorney fee are the only issues of the proceedings between the parties, and requires the director to refer the issue to the Board if the director is aware of proceedings between the parties before Board.

However, referring the penalty issue to the Board is not needed or appropriate in all cases. For example, if the hearing has already been held in the other proceedings or if the matter is at board review, the penalty issue should not be referred. To ensure penalty issues are appropriately referred, the division is considering amending the rule to make referrals to the Board optional instead of mandatory.

Options
1) Amend OAR 436-060-0155(4) to state referrals to the Board are discretionary.
   (4) Jurisdiction over proceedings.
   The director has exclusive jurisdiction when the assessment and payment of penalties and attorney fees described in ORS 656.262(11) are the only issues of the proceedings between the parties. ~~The director will not issue an order assessing a penalty or attorney fee under this rule when the same parties have initiated proceedings before the board.~~

   (a) If the director receives a request for penalties and attorney fees under this rule, and is aware of proceedings between the parties before the board, the director may~~will~~ refer the request to the board.
   (b) If the director has not been made aware of the proceeding before the board and issues a penalty order that becomes final, the director's penalty will stand.

2) No change.
3) Other.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Jovanna Patrick requested that this change be narrowed. Jovanna commented that, as written, the change may result in unintended consequences. She requested that the rule be made discretionary under particular circumstances only, such as when the hearing has already taken place or already started.

Issue 3

Rule: OAR 436-060-0170(1) Benefits paid a worker

Issue: The rule limits recovery of overpayments to methods specified in 656.268(14). However, ORS 656.268(14) does not limit overpayment recovery to only the methods specified in the statute. Additionally, the rule does not mention overpayment recoveries that are also permitted under ORS 656.268(12) and (13).

Background:
OAR 436-060-0170(1) describes when an overpayment of benefits may be recovered. Effective Jan. 1, 2024, the rule states:

> "An insurer may only recover overpayment of benefits paid to a worker as specified by ORS 656.268(14) and (16), unless authority is granted by an administrative law judge or the board."
>
> Note: House Bill 4138 (2022) added subsection (16) to ORS 656.268. See Oregon Laws 2022, Chapter 73.

Under ORS 656.268(14) and (16), insurers are permitted to recover overpayments of compensation payable to the worker. These subsections include the following:

- A limit on how much can be recovered from an individual temporary disability or permanent total disability payment, without prior authorization from the worker.
- A limit on how much can be recovered from a worker's permanent partial disability compensation.

The division has noted that the rule may be inadvertently narrower than ORS 656.268 because it includes the word "only." Although the statute provides limits on recovering overpayments from certain benefits, it does not address all possible ways an overpayment might be recovered. For example, instead of recovering from disability benefit payments, an insurer might recover an overpayment from a worker's mileage reimbursement. This method of recovery is not specifically mentioned in the statute, but is not prohibited. However, the "only" in the rule may be interpreted as saying that this overpayment cannot be recovered from mileage reimbursements.

Additionally, ORS 656.268 (12) and (13) also relate to overpayments. These subsections allow for adjustments in a notice of closure, and credits or offsets when benefits were obtained through fraud.

To ensure the rule accurately reflects the overpayment provisions of ORS 656.268, the division is considering clarifying the rule.

Options
1) Amend OAR 436-060-0170(1) to remove "only."

436-060-0170 Recovery of Overpayment of Benefits

(1) Benefits paid a worker.
An insurer may ~~only~~ recover overpayment of benefits paid to a worker as specified by ORS 656.268(14) and (16), unless authority is granted by an administrative law judge or the board.

2) Amend OAR 436-060-0170(1) to remove "only" and add citations of ORS 656.268.

436-060-0170 Recovery of Overpayment of Benefits

(2) Benefits paid a worker.
An insurer may ~~only~~ recover overpayment of benefits paid to a worker as specified by ORS 656.268(12), (13), (14), and (16), unless authority is granted by an administrative law judge or the board.

3) No change.
4) Other?

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:
Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Thais Lomax noted a preference for Option 2, as it provides greater clarity than Option 1.
- Deanna Judd asked if there was a limit as to how much can be recovered at one time.
- Summer Tucker commented that she believed that if an insurer wanted to recover an overpayment from temporary disability payment or permanent total disability payments, it is a 25% limit by default, and can be more if authorized by the worker. She believed the limit for PPD payments to be 50%, but noted that she would need to research to be certain.
- Jovanna Patrick commented that she has concerns about expanding what is applied to overpayments. Jovanna questioned taking mileage reimbursement when mileage payment is a medical benefit. Jovanna noted that she was not supportive of extending the rule to allow further expansion of what can be recovered outside of what the statute allows.
- Julie Riddle noted that she is used to the rule expanding on the statute and noted that it is not immediately clear what could be recovered under each instance. She suggested expanding this to make it clear how the overpayments are to be recouped, if one benefit can take from the other, if there are limits.
- Steven Bennett agreed that he preferred Option 2, as it provides greater clarity than Option 1.
- Elaine Schooler agreed that she preferred Option 2, as it provides greater clarity than Option 1.

Issue 4

Rule: OAR 436-060-0150(4) Timely payment of temporary disability

Issue: If approved by the insurer, employers are allowed to pay temporary disability on their payroll schedule. However, the rule does not allow an insurer to pay on the employer's payroll schedule. Additionally, the rule does not clearly state whether a self-insured employer may pay temporary disability on the self-insured employer's payroll schedule.

Background:
When a worker is entitled to temporary disability, ORS Chapter 656 and OAR Chapter 436 specify when payments must be made. After the first temporary disability payment, subsequent payments must be paid at least once each 14 days, under ORS 656.262(4)(a) and OAR 436-060-0150(4)(b).

In general, insurers are responsible for issuing temporary disability payments and must pay every 14 days. However, if approved by the insurer, the employer is allowed to issue temporary disability payments under OAR 436-060-0020(1). If an employer pays temporary disability, OAR 436-060-0150(4)(b)(A) indicates that the employer may make the payments concurrently with their payroll schedule. This option is only available for employers; insurers cannot pay on the employer's payroll schedule.

In previous rulemaking, a stakeholder recommended amending OAR 436-060-0150 to allow insurers to pay temporary disability on the employer's payroll schedule. Revising the rule as suggested could address the following issues:

- *Accuracy of temporary partial disability payments*
  If a worker is entitled to temporary partial disability (TPD), that benefit is calculated based on any post-injury wages they earn while performing modified work. However, in many claims, the period temporary disability is paid for is different than the employer's pay period. Division auditors have observed this can cause difficulty in calculating an accurate payment amount before it is due. For example:
    - A TPD payment for the 1st – 10th of the month is due on the 15th.
    - Worker timecards for the 1st – 15th aren't turned in until the 18th.
    - Since a payment is due on the 15th, but the post-injury wages aren't available before then, an estimate of the post-injury wages is used to determine how much TPD should be paid. In some cases, payment corrections are necessary if that estimate is incorrect.

- *Temporary disability and regular paychecks paid on different schedules*
  Currently, a worker who has returned to modified work but is not earning their full wages will receive a paycheck from their employer, and a separate temporary disability payment from the insurer. But, in many cases, the schedule for temporary disability payments is different than the employer's paycheck schedule. It may be more convenient and less confusing for a worker to receive their paycheck and their temporary disability payment around the same time, for the same period.

- *Self-insured employers*
  The current rule does not clearly state whether a self-insured employer may pay temporary disability on the self-insured's payroll schedule. Since a self-insured employer qualifies as an employer, it seems that a self-insured employer should be able to follow their payroll schedule. However, it may be beneficial to clarify the rule.

The division invites stakeholder input on the following options regarding allowing insurers to pay temporary disability on the employer's payroll schedule.

Options:

1) Amend OAR 436-060-0150(4) to allow insurers, self-insured employers, or employers to make temporary disability payments in accordance with the employer's payroll schedule.

   (4) Timely payment of temporary disability.
   Insurers must timely process the first payment of temporary disability compensation. The first payment of temporary disability on a claim must also include all temporary disability benefits due as of the date of payment, unless there is a reasonable basis to exclude those benefits at the time the payment issued. The director may assess a penalty under OAR 436-060-0200 against an insurer that does not make the first payment of temporary disability under the time frames of this section, or does not accurately report timeliness of first payment information.

   … (subsection (a) is omitted)
   (b) Subsequent payments of temporary disability benefits must ~~:~~
   ~~(A) B~~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) I~~include all benefits due for the period ending no more than seven days before the payment date. An insurer, self-insured employer, or employer making payments under OAR 436-060-0020(1) may pay temporary disability benefits in accordance with the employer's payroll schedule and pay period.

2) Amend OAR 436-060-0150 to include a requirement that written documentation of the employer's payroll schedule must be included in the insurer's claim file.

3) Amend OAR 436-060-0150 to require the insurer or self-insured employer to obtain the worker's permission to pay or stop paying temporary disability on the employer's payroll schedule.

4) No changes.
5) Other.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Amber McMurry commented the rule language is currently ambiguous and the language in Option 1 provides helpful clarification. Amber added that the amendment requiring written documentation of the employer's payroll schedule is important for auditors at the Workers' Compensation Division; when auditors come into an audit, this rule will make it so there is something showing the auditor when the payment should be made because it's based on that employer's schedule. Finally, Amber added that the third piece—to require worker's permission—is more difficult. Amber expressed concerns about requiring worker permission because it is often difficult to get information or responses from workers.
- Jovanna Patrick agreed with Amber's comments and added that she appreciates these changes, as trying to calculate whether temporary disability is due or hasn't been paid on a 14-day schedule that doesn't align with a pay schedule is difficult. Jovanna added that she agrees with Amber regarding the requirement of worker permission. Jovanna added workers receive tons of documents and requiring their permission may cause delays. Further, many workers expect the disability payments to align with their payroll.
- Julie Riddle agreed with the comments of Amber and Jovanna. Julie recommended adding language to Option 2 clarifying that the written documentation is only required when paying on the employer's pay schedule. Julie added that she did not think seeking permission from the worker was necessary; she believes it would be sufficient to keep them informed.
- Elaine Schooler agreed with the earlier comments: this change would ease administration of temporary disability and improve accuracy. She noted her agreement with Option 1 and Option 2. She agreed with earlier comments that requiring permission from the worker would hurt efficiency.
- Kirsten Adams agreed with previous comments supporting Option 1 and Option 2.
- Abby Smith via the Teams chat agreed with Amber McMurry's comments.

Background for issues 5 – 9

When there is a dispute over which employer or insurer is responsible for a worker's claim, the division can designate one of the insurers to temporarily process the claim (also referred to as designating a paying agent). The insurer selected to be the paying agent processes the claim until the responsibility dispute is resolved by the order of an administrative law judge.

The division can only designate a paying agent if all of the insurers agree the claim is compensable. Otherwise, the division cannot make a designation. The process and requirements for designating a paying agent are outlined in OAR 436-060-0180.

Issue 5

Rule: OAR 436-060-0180 (7) Failure to respond to request for clarification.

Issue: The timeframe for insurer response to the division's request for information may be longer than necessary.

Background:
If the division receives a request to designate a paying agent, the division must verify that all the insurers agree the claim is compensable. In cases where there is reasonable doubt about the claim's compensability, the division will request written clarification before selecting a paying agent. The insurer is required to respond within 21 days of the mailing date of the division's request, under OAR 436-060-0180(7).

Data collected by the division shows that insurers typically respond to a request for clarification within 13 days. Since the timeframe in rule is longer than the average response time, allowing 21 days for response may not be necessary. Additionally, a longer response timeframe may delay payment of the worker's benefits. A worker might not receive benefits until the paying agent has been designated.

The division proposes revising the response timeframe in the rule from 21 to 14 days. The timeframe of 14 days would be consistent with several other rules in chapter 436 regarding response to division requests. The division invites input from stakeholders on the following options.

Options:

1) Revise OAR 436-060-0180 to reduce the timeframe for response from 21 to 14 days.
   (7) Failure to respond to request for clarification.
   When notified by the director that there is a reasonable doubt as to the status of the claim or intent of a denial, the insurer must provide written clarification to the director, the worker, the other insurers involved and other interested parties within 14~~21~~ days of the mailing date of the notification. If an insurer fails to respond timely or provides an

inadequate response (e.g., failing to answer specific questions or provide requested documents), the director may assess a civil penalty under OAR 436-060-0200.

2) Reduce the timeframe for response from 21 to 14 days, and change the trigger for the start of the timeframe.

(7) Failure to respond to request for clarification.
When notified by the director that there is a reasonable doubt as to the status of the claim or intent of a denial, the insurer must provide written clarification to the director, the worker, the other insurers involved and other interested parties within 1421 days of the date of receiptmailing date of the notification. If an insurer fails to respond timely or provides an inadequate response (e.g., failing to answer specific questions or provide requested documents), the director may assess a civil penalty under OAR 436-060-0200.

3) No change to the rule.
4) Other.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:
Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Drew Lindsey noted that, due to inconsistencies with the mail, he prefers Option 2.
- Thais Lomax expressed a preference for Option 2.
- Steven Bennett noted that he did not believe a change needed to be made. He noted that, if insurers are providing responses faster than the given timeline, there is no need to shorten the timeline. He recommends keeping the 21-day timeline. However, if a change is to be made, Steven expressed a preference for Option 2.
- Julie Riddle agreed with Steven's comments. She asked about the data used to reach the 13-day average, and noted that quick responses could skew an average. She noted that the average of 13 days is close to the proposed change to 14 days and recommended keeping the 21-day time limit. However, if a change is to be made, Julie expressed a preference for Option 2 (due to inconsistencies with the mail).
- Elaine Schooler raised similar questions regarding the data to reach the 13-day average. If a change is to be made, Elaine preferred Option 2 over Option 1 (due to inconsistencies with the mail).
- Keith Semple supported the 14-day timeline change, and noted that OTLA would prefer to see a shorter timeline to keep the processing moving. He added that a response regarding clarification should not take a lot of processing or investigation time. Keith noted option 2 is fine, but did not have concerns regarding date of mailing or date of receipt.

Issue 6

Rule: OAR 436-060-0180(9) Factors for designation

Issue: The terminology used in this rule regarding permanent disability has changed.

Background:
To select a paying agent, OAR 436-060-0180(9) specifies that the division will designate the insurer with the lowest compensation, considering certain factors. One of the factors is the "rates per degree of permanent disability."

For dates of injury before Jan. 1, 2005, permanent partial disability (PPD) was calculated based on dollar rates per degrees of impairment (for example, $184.00 for 60 degrees). However, for dates of injury on or after Jan. 1, 2005, permanent partial disability is calculated based on the state average weekly wage. Since there are differences in how PPD is calculated depending on the date of injury, the division has identified that referring to the "rates per degree of permanent disability" is not accurate for dates of injury on or after Jan. 1, 2005.

Options:

1) Amend OAR 436-060-0180(9) as follows:

(9) Factors for designation.
Upon receipt of written acknowledgment from the insurers that the only issue is responsibility for an otherwise compensable injury claim, the director will issue an order designating a paying agent under ORS 656.307. The director will designate the insurer with the lowest compensation considering the following factors:

(a) The claim with the lowest temporary total disability rate;

(b) If the temporary total disability rates and the rates of permanent partial disability ~~rates per degree of permanent disability~~ are the same, the earliest claim;

(c) If there is no temporary disability or the temporary total disability rates are the same, but the rates of permanent partial disability~~rates per degree of permanent disability~~ are different, the claim with the lowest rate of permanent partial disability~~per degree of permanent disability~~;

2) No change to the rule.

3) Other.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Elaine Schooler asked for clarify; she asked if the Option 1 proposed language referencing rates of permanent partial disability includes rates from before and after January 1, 2005.
- Summer Tucker confirmed that yes, the new language is meant to include both.

Issue 7

Rule: OAR 436-060-0180 (9) Factors for designation

Issue: The division may select a paying agent based on which claim is the "earliest," but the rule does not define what "earliest claim" means.

Background:
To select a paying agent, OAR 436-060-0180(9) specifies that the division will designate the insurer with the lowest compensation, considering six factors. If no other factors apply, the last factor the division will consider is which insurer has the "earliest claim." This factor is only considered if the temporary total disability rates and rates per degree of permanent disability are the same for all the insurers.

The term "earliest claim" is not defined in the rule. Based on the statutory definition of "claim" in ORS 656.005(6) the earliest claim would be the earliest "…*written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge."*

To ensure the rule is clear, the division is considering adding a definition of "earliest claim" to the rule, based on the statutory definition of "claim."

Options:
1) Amend OAR 436-060-0180(1) as follows:

(1) For the purpose of this rule:
… (subsections a – c omitted)
(d) "Earliest claim" means the earliest date of:
(i) A written request for compensation from a subject worker or someone on the worker's behalf; or
(ii) The subject employer had notice or knowledge of the compensable injury.

2) Other
3) No change.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:
Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- No discussion.

Issue 8

Rule: OAR 436-060-0180(9) Factors for designation

Issue: The division may select a paying agent based on the "earliest claim." But in some cases, it may not be possible to determine which claim is the earliest.

Background:
OAR 436-060-0180(9)(b) specifies that the division will designate the insurer which has the "earliest claim" when other factors included under this section do not apply.

In some cases, the date of the "earliest claim" may be the same for all insurers involved in a responsibility dispute. For example, with an occupational disease claim, the worker may file a claim with multiple employers and insurers all on the same day. However, the rule does not state which insurer should be designated the paying agent if the "earliest claim" date is the same for all claims.

To address this issue, the division is considering adding rule language to state the division may consider other information if the "earliest claim" factor does not indicate which claim should be selected as the paying agent.

Options:

1) Revising OAR 436-060-0180 (9) as follows:

   (9) Factors for designation.

   Upon receipt of written acknowledgment from the insurers that the only issue is responsibility for an otherwise compensable injury claim, the director will issue an order designating a paying agent under ORS 656.307.

   (a) The director will designate the insurer with the lowest compensation considering the following factors:

      (A~~a~~) The claim with the lowest temporary total disability rate;
      (B~~b~~) If the temporary total disability rates and the rates per degree of permanent disability are the same, the earliest claim;
      (C~~c~~) If there is no temporary disability or the temporary total disability rates are the same, but the rates per degree of permanent disability are different, the claim with the lowest rate per degree of permanent disability;
      (D~~d~~) If one or more claims have disposed of benefits in accordance with ORS 656.236(1), the claim providing the lowest compensation not released by the claim disposition agreement;
      (E~~e~~) If one claim is under own motion jurisdiction, that claim, even if it is not the claim with the lowest temporary total disability rate; and

(F~~f~~) If more than one claim is under own motion jurisdiction, the own motion claim with the lowest temporary total disability rate.

(b) If the claim with the lowest compensation cannot be determined under subsection (a) of this section, the director may consider other information to designate a paying agent.

2) No changes.
3) Other.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:
Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- No discussion.

Issue 9

Rule: OAR 436-060-0180(6)(c) Request for designation of a paying agent

Issue: The rule requires insurers to provide certain information when requesting designation of a paying agent. However, some of the information required for the division to designate a paying agent is not included in the rule.

Background:
When an insurer requests that the division designate a paying agent, the rule requires that the following information must be included:

- Identification of the compensable injuries or occupational diseases
- That the insurer is requesting designation of a paying agent under ORS 656.307
- That the insurer acknowledges the claim is otherwise compensable
- That responsibility is the only issue
- Identification of the specific claims or exposures involved by:
    - Employer
    - Insurer
    - Date of injury or specific period of exposure
    - Claim number, if assigned
- Acknowledgment that medical reports and other material pertinent to the injury have been provided to the other parties
- Confirmation the worker has been advised of the actions being taken on the worker's claim.

The division identified that in addition to the list above, the following information is needed to select a paying agent, but is not included in the rule:

- The worker's average weekly wage, and
- The earliest date of the written request for compensation from a subject worker or someone on the worker's behalf, or the earliest date the subject employer had notice or knowledge.

To ensure that the division receives all the information needed to designate a paying agent and avoid delays, the division is considering amending the rule to update the list of required information.

Options:

1) Amend OAR 436-060-0180(6) to include the average weekly wage and earliest claim date.

(6) Request for designation of a paying agent.

(c) The insurer's written request must contain the following information:
(A) Identification of the compensable injuries or occupational diseases;
(B) That the insurer is requesting designation of a paying agent under ORS 656.307;

(C) That the insurer acknowledges the claim is otherwise compensable;
(D) That responsibility is the only issue;
(E) Identification of the specific claims or exposures involved by:
(i) Employer;
(ii) Insurer;
(iii) Date of injury or specific period of exposure; and
(iv) Claim number, if assigned;
(F) Acknowledgment that medical reports and other material pertinent to the injury have been provided to the other parties; ~~and~~
(G) Confirmation the worker has been advised of the actions being taken on the worker's claim;~~.~~
(H) The worker's average weekly wage, as calculated under OAR 436-060-0025; and
(I) The date of the written request for compensation from a subject worker or someone on the worker's behalf, or the date the subject employer had notice or knowledge of the compensable injury, whichever is earliest.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Elaine Schooler asked about the average weekly wage calculation. She asked if there could there be additional language added to state that average weekly wage should be provided after it has been calculated or is known. She noted there are times when the insurer does not yet have the payroll records from the employer to make the determination.
- Summer Tucker noted that WCD would take Elaine's comments under consideration.

Issue 10

Rule: OAR 436-060-0010 Employer Responsibilities

Issue: A worker may not be aware of their medical treatment rights when using their employer's on-site medical service provider to assess their injury.

Background:
Workers' compensation law prohibits employers from directing a worker to see a specific medical provider (also known as "direction of care"). However, ORS 656.260(21)(b)(B) allows for an employer to use an on-site medical service facility to assess the nature or extent of a worker's injury.

The division has recently received complaints regarding workers' employers directing them to use the on-site medical service facility beyond the initial assessment. The issues identified in these complaints were:

- The employer directing the worker to an on-site physical therapy facility on multiple occasions. There was delay in filing the claim, and the worker later required surgery for their injury-related condition.
- The employer directing the worker to multiple on-site providers, specifically, to an on-site emergency medical technician, an on-site physical therapy provider, and out-of-state telemedicine provider.

If an employer inappropriately directs a worker's medical care, or prevents a worker from filing a workers' compensation claim, the division has the authority to issue civil penalties. The division will also often provide education and training prior to issuing a civil penalty. However, these enforcement actions do not directly prevent direction of care issues from occurring. It is important that a worker understands their right to receive medical treatment from a health care provider of their choice, and that their employer is prohibited from directing them where to go for medical treatment.

To ensure workers are informed of their medical treatment rights, the division is considering implementing a rule requirement that the employer must provide the worker Form 3283 at the time an on-site assessment occurs. Form 3283 is the division publication "A Guide for Workers Recently Hurt on the Job", and includes information on how to file a claim, get medical treatment, and limitations on medical treatment.

The division invites stakeholders to provide input on the following options, or other rule revisions that could address the issue.

Options

1) Add a requirement to OAR 436-060-0010 that the employer must provide Form 3283 during the assessment of the nature or extent of an injury if all of the following conditions are met:
    - The worker informs the employer or employer's on-site medical service facility of a work related injury.

- The nature or extent of the worker's injury is assessed at the employer's medical service facility.

2) No change.

3) Other.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:
Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Drew Lindsey expressed concerns about certain issues surrounding on-site medical service facilities. He noted an incident in which an employer tried to go into the hospital room with the doctor and worker when the worker was hurt on the job. He stated that he wished to see more to protect people when they get hurt and to stop employers from intervening with care.
- Keith Semple stated that providing a pamphlet was not sufficient to rectify this issue and that more needs to be done to prevent employers from directing care of workers. He would like to see greater measures taken to prevent employers from telling workers they need to be seen on-site. If anything is going to be handed out, Keith suggested it state more clearly the rule, that the worker has a right to make their own decision about filing a claim, an employer is prohibited from directing care, and that there is a recourse for workers and a penalty for employers in the event the rule is not followed. Keith expressed a wish that the department become more involved with rectifying the issue of employers directing care.
- Thais Lomax agreed with Keith Semple's comments. She noted that she knows of several employers with on-site medical facilities and suggested that a poster stating the rule in bold text, rather than a brochure, may be more impactful.
- Kirsten Adams (by phone) commented that she wanted to make sure the requirements wouldn't put the employer in a position to potentially violate HIPAA or otherwise require the employer to get involved in a way that requires disclosure of information to employer that wouldn't otherwise be allowed.
- Amber McMurry requested a carve out for adults in custody or sentenced inmates; Amber noted that these individuals are not permitted to leave unless the injury is severe enough to require hospitalization. Amber then added a general question about enforceability of this rule: who would verify employers are providing materials to employees?
- Julie Riddle questioned the initial intent of this rule. Specifically, she wondered if this rule was meant to allow on-site facilities to determine the degree of care required (merely first aid or something more significant?) and have all other medical services provided elsewhere. And, if the intent was merely to allow the on-site facility to make the initial determination, Julie suggested making that clear in the rule. Julie suggested more clarification be provided to demonstrate what was and what was not allowed.

- Lauren Rolater agreed with Julie's suggestion to make a carve out for employers to provide the initial consultation determining if first aid or additional treatment is needed.
- Joshua Carter noted that he is aware of employers/contractors that are putting it in their policies requiring employees go to the on-site facilities. Josh agreed with Keith Semple that more needs to be done to make workers aware of their rights. He voiced concern that a poster or a brochure would not be sufficient.
- Virginia Jones (via the chat) agreed with Amber McMurry's comments.
- Keith Semple added that, after listening to the comments, he believed more action needs to be taken to prevent employers from directing care. He suggested prohibiting on-site facilities from treating workers. He noted that an employer's inability to direct care is not compatible with the authority employers have under the rule as-is. He added that it would be fine for an on-site facility to handle first aid, but assessing an injury and determining what level of care was necessary still concerned him; he reiterated that a poster or brochure would not suffice to protect workers' rights. He echoed Amber's question regarding enforceability by asking who would confirm employers are providing information to employees.
- Steven Bennett cautioned the division not to overdo it when considering this issue. He noted that employers are not allowed to direct care but they are allowed to have on-site medical service facilities to assess the nature and extent of workers' injuries. Steven emphasized that not every employer intends to direct care. He believes a pamphlet telling workers of their rights is enough. He again cautioned the division not to go overboard when considering this issue, and added that the division can look into cases where direction of care occurs.
- Kirsten Adams (by phone) agreed with Steven Bennett's comments and emphasized the important role of these facilities. She suggested that, if changes are made, they be more targeted as opposed to some blanket prohibition on care.
- Abby Smith (via the chat) noted that there is a benefit to on-site medical care, but it should be stated that these facilities are for an initial medical treatment only.

Issue 11

Rule: OAR 436-060-0030(1)(c) Rate of temporary partial disability

Issue: OAR 436-060-0035 provides that when a worker is partially disabled and eligible for supplemental disability, temporary partial disability is calculated under OAR 436-060-0030. However, OAR 436-060-0030 includes a provision that should not be applied when a worker is eligible for supplemental disability.

Background:
When a worker is temporarily disabled from work, they receive temporary total disability (TTD) if totally disabled, or temporary partial disability (TPD) payments if partially disabled.

- TTD payments are 66 2/3% of the worker's average weekly wage before the injury.

- TPD payments are calculated by reducing the TTD payment based on the percentage of wages lost after the injury. For example, if a worker loses 50 percent of their wages post-injury, their TPD payment is 50 percent of the TTD payment. The percentage of wages lost is determined based on the wages the worker receives after their injury (post-injury wages).

If a worker has multiple jobs at the time they are injured, they may also be eligible for supplemental disability benefits. Supplemental disability benefits (SDB) provide compensation for wages lost at a second job. For example, if a worker was injured at job A only, but loses wages from job A *and* job B because of the injury, they may be eligible for SDB.

When a worker is eligible for SDB, they may receive an increased TTD or TPD benefit.

- TTD payments are 66 2/3% of the worker's combined average weekly wage from the primary *and* the secondary jobs.

- TPD payments are calculated based on reducing the TTD payment based on the post-injury wages. The post-injury wages include wages from the primary *and* secondary jobs.

OAR 436-060-0035(7)(a) states that when a worker is eligible for SDB, the insurer must calculate the TPD due under OAR 436-060-0030 based on the wages from both the primary and secondary jobs. However, OAR 436-060-0030 contains a provision that should not be applied to SDB. Specifically, OAR 436-060-0030(1)(c) states:

> "Wages from a secondary employer must only be included in post-injury wages to the extent that the wages from the secondary employer post-injury exceed the wages from the secondary employer at the time of injury."

This rule indicates the post-injury wages used to calculate TPD should only include wages from a second job if they *exceed* the wages from the second job at the time of injury (i.e., if the worker

earned $100 at the second job at the time of injury, but earned $150 after the injury, the post-injury wages should only include $50).

If this provision was applied to an SDB eligible worker, they would be overpaid, since the TPD calculation would not account for all the post-injury wages the worker has received.

The language in (1)(c) has been in place since 1992, and was intended to limit when wages from a second job were included in TPD. This clarification occurred before the SDB program was established in 2002. Given that the rule predates the program, it appears that (1)(c) was not intended to apply when the worker is eligible for SDB. The division believes the rule may need to be clarified to avoid confusion.

Options

1) Specify that (1)(c) only applies if a worker is *not* eligible for supplemental temporary disability.

436-060-0030 Payment of Temporary Partial Disability Compensation
(1) Rate of temporary partial disability.
(a) To calculate the rate of temporary disability, the insurer must:
(A) Subtract the worker's post-injury wages from any kind of work from the worker's wages at the time of injury under OAR 436-060-0025;
(B) Divide the difference under paragraph (A) by the worker's wages at the time of injury under OAR 436-060-0025 to arrive at the percentage of loss of wages; and
(C) Multiply the worker's current rate of compensation for temporary total disability by the percentage of loss of wages in paragraph (B).

(b) As used in this rule "post-injury wages" means the sum of:
(A) The wages the worker could have earned by accepting a job offer, or actual wages earned, whichever is greater;
(B) Any unemployment benefits received; and
(C) Any wages received for paid leave, except wages paid in addition to temporary disability compensation with the worker's consent under OAR 436-060-0025(1);

(c) If a worker is not eligible for supplemental disability under OAR 436-060-0035, w~~W~~ages from a secondary employer must only be included in post-injury wages to the extent that the wages from the secondary employer post-injury exceed the wages from the secondary employer at the time of injury.

2) No change.
3) Other.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Keith Semple (via the chat) noted that it is a good idea to clarify the supplemental disability offset rules as outlined in Option 1.

Issue 12

Rule: OAR 436-060-0170 Recovery of Overpayment of Benefits
OAR 436-060-0500 Reimbursement of Supplemental Disability for Workers with Multiple Jobs at the Time of Injury

Issue: When supplemental disability benefits have been overpaid, the process for recovering the overpayment and correcting related reimbursements from the Workers' Benefit Fund is unclear.

Background:
When a worker is temporarily disabled, they may receive temporary disability payments for the time they lose from their job. Additionally, if the worker had multiple jobs when they were injured, they may also be eligible for supplemental temporary disability benefits (SDB). When eligible, the worker receives SDB to compensate for wages lost at secondary jobs. For example, if a worker was injured at job A, but loses wages from job A *and* job B, SDB provides additional compensation for wages lost from job B.

SDB is paid by either the insurer or an assigned processing administrator selected by the division. The insurer or assigned processing administrator is later reimbursed for the amount of SDB paid. The division issues these reimbursements from the Workers' Benefit Fund (WBF).

In some cases, the insurer or the assigned processing administrator may identify that SDB has been overpaid. Additionally, it is possible that the insurer or processing administrator was reimbursed for those overpayments from the WBF.

The division has identified two issues related to overpayments of SDB.

- OAR 436-060-0500 does not state what the insurer must do if they find an overpayment of SDB reimbursed from the WBF (i.e., when and how the overpayment must be repaid to the WBF.)

- Under OAR 436-060-0170, an insurer may recover an overpayment of benefits from a worker. However, SDB is paid by either the insurer or the assigned processing administrator. When an overpayment of SDB occurs, the rule is unclear in regards to which entity should recover the overpayment.

The division believes that revisions to OAR 436-060-0170 and 436-060-0500 would ensure the process for recovering overpayments and correcting related reimbursements is clear for all parties. The division invites input from stakeholders on the following options.

Options
1) Amend OAR 436-060-0170 to state the assigned processing administrator may request that the insurer recover an overpayment of supplemental disability benefits from the worker.

2) Amend OAR 436-060-0170 to state the assigned processing administrator may recover an overpayment of supplemental disability benefits from the worker.

3) Amend OAR 436-060-0500 to specify when and how to repay the Workers' Benefit Fund, if the insurer or assigned processing administrator discover an overpayment of SDB.

4) No change.

5) Other.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Kevin Anderson stated a preference for Option 2 as this would allow the processing administrator to recover their own overpayment for their supplemental disability benefits rather than asking the insurer to recover those benefits. He noted that, if there is litigation, it could be uncomfortable for the insurer to defend an overpayment of supplemental disability when another party was handling that.

Issue 13

Rule: OAR 436-060-0017 Release of Claim Documents

Issue: Stakeholders recommended expanding the disclosure requirements of OAR 436-060-0017(1).

Background:
OAR 436-060-0017(3) provides that insurers or service companies must provide copies of claim documents when requested by the worker and worker's attorney at times other than those provided under ORS 656.268 and OAR Chapter 438. OAR 436-060-0017(1) provides what records are considered "documents" that are subject to disclosure:

- Medical records, including any correspondence to and from medical experts who provide reports to the insurer
- Vocational records, including any correspondence to and from vocational experts who provide reports to the insurer
- Records of all compensation paid
- Payroll records
- Recorded statements
- Insurer generated records, excluding a claims examiner's generated file notes, such as documentation or justification concerning setting or adjusting reserves, claims management strategy, or any privileged communications
- All forms and notices on the claim required by ORS chapter 656 or OAR chapter 436;
- Notices of closure
- Electronic transmissions and correspondence between the insurer, service providers, worker, director, or board.

In 2021, this rule was revised to make minor changes to be more consistent with the Workers' Compensation Board's rules on disclosure of claim documents. In testimony, some stakeholders recommended that the division expand the list of documents subject to disclosure to include the following:

- Any correspondence to and from medical or vocational experts.
- Investigative statements and summaries
- Insurer generated records, *including* a claim examiner's generated file notes or claims management strategy.

Additionally, in October 2023, a stakeholder submitted a similar rule issue, recommending that the "…insurer should provide all correspondence relating to the claim with any exceptions listed."

The recommendations provided in testimony were not implemented in 2021, but the division preserved this issue for future rulemaking discussion. The division seeks stakeholder feedback on the following:

- Should the list of documents that must be disclosed be expanded?

- Are other clarifications needed regarding what documents must be disclosed?

Options
To be determined based on stakeholder feedback.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Thais Lomax noted concerns with a broad based file notes requirement; she added that claim files often document confidential or financial information; this documentation is not substantive to claimant counsel, but documentation is needed. So, Thais would like to greater specificity regarding "file notes."
- Steven Bennett voiced strong opposition to expanding the list of documents; he added that most of what is appearing on the list is confidential, proprietary and work product. Steven doubted that these items would be discoverable in other states and raised a concern about the potential of disclosing information during a fraud investigation, which should not be done. Steven noted he did not see a reason for including investigative statements and summaries, or claim management strategy, and that claimant attorneys have their own strategy, which is not shared.
- Amber McMurry agrees that some of the documents should not be included. She noted that turning over claim strategy notes defeats the purpose of having a strategy. She echoed Steven Bennett's concerns regarding disclosure during a fraud or credibility investigation. Finally, Amber noted that there are certain materials that, if shared, would be detrimental to the employee; she urged that such things should not be included in a general release of documents.
- Keith Semple noted that Oregon Trial Lawyers brought this issue forward and, in light of the comments, voiced a preference that non-discoverable materials be listed out as opposed to trying to codify a general list of discoverable materials.
- Elaine Schooler echoed earlier concerns regarding file notes, claim management strategy and privileged communications. She noted that business records and documents regarding reserving care valuation or fraud issues, as well as documented discussions with attorneys should all remain privileged. She added that a rule change of this nature would result in a significant administrative burden, as insurers would need to go through notes and make redactions. And, she added that a dispute would require some sort of resolution process and review from a third party. Elaine asked what that resolution process would look like and who would be involved: an administrative law judge or some other legal professional? Elaine raised similar concerns about including investigative statements and summaries—particularly in circumstances involving credibility or fraud issues. Elaine added that the rule already provides for "recorded statements" as well as correspondence to and from medical or vocational experts. Because those things already exist in rule, she wondered what these additions were meant to capture.
- Kirsten Adams agreed with Elaine Schooler in terms of protecting what needs to be protected and noted that the list should not be expanded.

- Lauren Rolater agreed with earlier comments opposing expansion and emphasized that the administrative burden of implementing this change would be significant.
- Elaine Schooler added, with respect to the administrative burden, that insurers needing to redact and review materials and still send materials on a 14-day basis would be extremely difficult for the insurer.
- Abby Smith echoed earlier comments opposing expansion and noted that claim notes, investigation documents, and strategy notes were all work product and should not be subject to disclosure.
- Thais Lomax added that there would be a significant financial burden if this change were implemented. Thais noted that, currently, non-litigated files of represented workers are generally not assigned separate defense counsel. However, adding a need for redaction and legal review of general discovery would require those additional legal costs for employers and insurers. Adjusters would not be able to sort through material as required for those non-litigated claims.

Issue 14

Rule: OAR 436-060-0135(2)(b)(E) Request to suspend compensation

Issue: Insurers must submit specific information to the division to request suspension of a worker's benefits, including the worker's initial request for compensation (e.g., Form 801, or Form 827). However, the rule does not clearly state that Forms 801 or 827 are required.

Background:
Under OAR 436-060-0135, if a worker refuses or fails to cooperate in an investigation of the claim, the insurer may request that the director suspend the worker's compensation by order. Under OAR 436-060-0135(2)(b)(E), the insurer is required to provide certain information that demonstrates the worker's failure to cooperate, as follows:

- That the insurer requests suspension of benefits under ORS 656.262(15) and OAR 436-060-0135.
- Documentation of the specific actions of the worker or worker's attorney that prompted the request.
- Any reasons given by the worker for failure to comply, or a statement that the worker has not given any reasons.
- A copy of the insurer's notice to the worker that an interview or deposition was scheduled, or of other investigation requirements.
- All other pertinent information, including, but not limited to, a copy of the claim for a new or omitted condition when that is what the insurer is investigating.

To complete a review of the suspension request, the division needs documentation of when the worker filed the claim. Claims are frequently filed by completing Form 801 (Report of Job Injury or Illness), or Form 827 (Worker's and Health Care Provider's Report for Workers' Compensation Claims). Form 801 (or alternatively, Form 827) must be submitted to the division when the insurer accepts or denies the claim. However, if a suspension is requested before a claim has been accepted or denied, Forms 801 and 827 have not yet been submitted to the division.

The rule requires submitting "all other pertinent information", which includes Forms 801 and 827. However, the rule does not clearly include those forms. In some cases, those documents are not submitted, and additional follow up is required before review of the suspension request can begin.

To ensure the rule is clear regarding what documents are required for a suspension request, the division is considering amending the rule to specifically require providing the Form 801, 827, or other written documentation of the worker's request for compensation.

Options
1) Amend OAR 436-060-0135(2)(b) as follows:

(E) The insurer's request must include the following information sufficient to show the worker's failure to cooperate:

(i) That the insurer requests suspension of benefits under ORS 656.262(15) and this rule;

(ii) Documentation of the specific actions of the worker or worker's attorney that prompted the request;

(iii) Any reasons given by the worker for failure to comply, or a statement that the worker has not given any reasons;

(iv) A copy of the notice required in (2)(a) of this rule; ~~and~~

(v) All written documentation of the worker's request to file a claim, including, but not limited to, a copy of Form 801 and Form 827; and

(vi) All other pertinent information, including, but not limited to, a copy of the claim for a new or omitted condition when that is what the insurer is investigating;

2) No change.
3) Other.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Thais Lomax voiced a concern with the phrasing of the proposed part (v). She noted that they will often have an 801 or a 827—not both.
- Steven Bennett suggested a phrasing change in the proposed part (v). He cautioned using broad language such as "all written documentation." He stated that "all written documentation" could lead to issues in the event of a fraud investigation and is generally ambiguous. Steven had no issues with the requirement for an 801 or 827.
- Elaine Schooler noted that she had questions similar to those raised; she added that, in some circumstances, a worker will handwrite the information that would go on an 801 if the 801 is not available. Elaine added that the attorney may file it on the worker's behalf. She wanted to confirm that a lack of 801 or 827 forms would not cause delay if the information was otherwise made available (just not on the official forms).

Issue 15

Rule: OAR 436-060-0135(2)(c)(A) Request to suspend compensation

Issue: When notified by the division of a request to suspend benefits, the rule restricts the worker to responding by telephone or by mailing a letter.

Background:
Insurers may submit a request to the division that a worker's benefits be suspended under OAR 436-060-0135. When a suspension request is submitted, the division notifies the worker and their attorney that benefits will be suspended in five business days unless the worker or their attorney contacts the division and documents that the worker's failure to cooperate was reasonable.

The rule only allows response by telephone or mail, but the division considers other methods of response acceptable, such as faxing. The division believes the rule should be updated to include more options for responding to the division's notification.

Options
1) Amend OAR 436-060-0135 to remove specific methods of contacting the division.

(2) Request to suspend compensation.
The insurer may request for the director to suspend compensation by order when the worker refuses or fails to cooperate in an investigation of an initial claim for compensation, a claim for a new medical condition, a claim for an omitted medical condition, or an aggravation claim as required by ORS 656.262(14), under the following conditions:

…(subsections a and b omitted)

(c) After receiving the insurer's request to suspend benefits, the director will notify all parties that:
(A) The worker's benefits will be suspended in five business days unless:
(i) The worker or the worker's attorney contacts the division ~~by telephone or mails a letter documenting that~~and explains how the worker's failure to cooperate was reasonable; or
(ii) The insurer notifies the division that the worker is now cooperating;
(B) The insurer's obligation to accept or deny the claim within 60 days is suspended unless the insurer's request is filed with the division after the 60 days to accept or deny the claim has expired;

2) Amend OAR 436-060-0135 to add more options for contacting the division.

(2) Request to suspend compensation.
The insurer may request for the director to suspend compensation by order when the worker refuses or fails to cooperate in an investigation of an initial claim for compensation, a claim

for a new medical condition, a claim for an omitted medical condition, or an aggravation claim as required by ORS 656.262(14), under the following conditions:

…(subsections a and b omitted)

(c) After receiving the insurer's request to suspend benefits, the director will notify all parties that:

(A) The worker's benefits will be suspended in five business days unless:

(i) The worker or the worker's attorney contacts the division by telephone, ~~or~~ mail, fax, or in person ~~mails a letter documenting that~~and explains how the worker's failure to cooperate was reasonable; or

(ii) The insurer notifies the division that the worker is now cooperating;

(B) The insurer's obligation to accept or deny the claim within 60 days is suspended unless the insurer's request is filed with the division after the 60 days to accept or deny the claim has expired;

3) No change.
4) Other.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Elaine Schooler noted a preference for Option 2, as it spells out the various methods to contact the division and provides greater clarity than Option 1.
- Kirsten Adams (via the chat) agreed with Elaine and preferred Option 2.

Issue 16

Rule: OAR 436-060-0018(3)(d) Worker request for reclassification
OAR 436-060-0018(7)(a) Appeal of insurer's classification decision

Issue: When an insurer does not respond to a worker's request for reclassification, the worker is not notified that they may request review by the director, or of the time limit for requesting review.

Background:
Under OAR 436-060-0018, a worker may request that their claim be reclassified from nondisabling to disabling. Once the insurer receives the worker's request, the insurer must review and respond within 14 days. If the insurer denies the worker's request, they must mail a "Notice of Refusal to Reclassify."

Under OAR 436-060-0018(3)(d), if the insurer does not send any response, the worker may request review by the director under section (7) of the rule as if the insurer issued a Notice of Refusal to Reclassify. Section (7) of the rule provides that the worker must submit their request to the division within 60 days from the date of the insurer's notice.

If the insurer did not respond to the worker's request, the division considers the 60 day appeal period to start from the 14th day the insurer had to respond to the worker's request for reclassification.

A stakeholder requested that the rule be amended to allow the worker to request review by the director at any time, if the insurer does not respond to the worker's request for reclassification (rather than being limited to requesting within the 60 days noted above).

The division believes allowing a worker to request review without a time limit would conflict with other provisions of OAR 436-060-0018 that limit how long the worker can request reclassification of their claim to disabling. Section (3) of the rule provides that the worker may request reclassification if the claim has been classified as nondisabling for one year or less after the date of acceptance. Otherwise, section (5) provides that if a claim has been classified as nondisabling for at least one year after the date of acceptance, the worker must submit a claim for aggravation under ORS 656.273. Under ORS 656.273(4)(b), the claim for aggravation must be filed within five years of the date of injury.

Although allowing appeal without any time limit is not feasible, the division identified two issues related to the stakeholder's recommendation. First, if the insurer does not respond to the worker's request for reclassification, the worker may not be aware that they can request review by the director. Second, the worker may not be aware that there is a time limit to request review. The division seeks input from stakeholders on options for addressing those issues.

Options

1) Amend OAR 436-060-0018(7) to increase the time to request review in cases where the worker did not receive a Notice of Refusal to Reclassify.

2) Amend OAR 436-060-0018(7) to give the director discretion to review a worker's request if received after the 60 day appeal period elapses, but only in cases where the worker did not receive a Notice of Refusal to Reclassify.

3) No change.

4) Other.

Fiscal Impacts, including cost of compliance for small business:
How will adoption of this rule affect racial equity in Oregon?
Recommendations:

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Keith Semple noted that Oregon Trial Lawyers raised this issue after seeing workers barred from pursuing an appeal of reclassification request. He noted that, in the instance of de facto claim denials, there is no such limitation for the worker to appeal the insurer's inaction. Keith noted that in regards to the concern raised about the time for requesting reclassification, the request for reclassification has already been made, and did not see a conflict. To the extent that there needs to be a limitation, it could be specified where a deadline might be applied. Keith noted that it needs to be clear in the law what the process is and what the appeal rights are. Keith disagreed with the idea of the discretionary option. He recommended either an open-ended deadline, or if specific restrictions are needed to accommodate other statutory provisions, that those be specified.
- Steven Bennett does not believe a change is needed. He believes 60 days is a sufficient deadline and that, if workers do not hear back, they should consider the request denied and file an appeal.
- Elaine Schooler noted that there is an issue for workers who do not know they have 60 days to appeal when the insurer has not responded. She noted there is a tension between timelines for requesting reclassification and aggravation. She suggested giving workers up to that one year after the acceptance expires to request review from the director. She voiced opposition to an open-ended deadline, as well as the option regarding director discretion.
- Thais Lomax noted that the notice to workers is issued with every acceptance and states the timelines to request reclassification and division review. Thais noted that unrepresented workers may need additional assistance, but that it would be hard to state the timelines any clearer than they are already stated. Thais stated that 60 days after the 14 days for the insurer's response is a fairly good amount of time.

Issue 17

Rules: OAR 436-060-0018, 0020, 0030, 0095, 0105, 0135, and 0137

Issue: The prescribed notice wording in these rules is not easily understood by workers.

Background:
In March 2022, the Workers' Compensation Division invited interested parties to an advisory committee that identified and discussed opportunities to simplify and streamline notices distributed to workers and employers. Committee members advised that revisions of the content and format of notice language that is prescribed by rule could make the notices easier to understand.

Currently, OAR chapter 436 prescribes language for 30 notices. Many of these notices include information on the worker's rights, processes for appeals, and contact information for questions or assistance. When a rule requires that notices to workers or employers include specific wording, it is critically important that the text helps readers understand their rights and responsibilities. Failure to meet a deadline, for example, can result in suspension or termination of a worker's benefits, or loss of appeal rights.

The division drafted revised wording for review by the rulemaking advisory committee. The intent is to simplify and clarify the prescribed wording without changing the meaning.

Current wording and revised wording are presented below. These paragraphs are available with marked edits in the appendix.

OAR 436-060-0018(3)(b)(B)

Current, Grade 12:	**Draft, revised, Grade 6:**
"If you disagree with this Notice of Refusal to Reclassify, you may appeal by contacting the Workers' Compensation Division within sixty (60) days of the mailing date of this notice. You may appeal by using Form 2943, "Worker Request for Claim Classification Review," available on the division's website at wcd.oregon.gov. **Send written appeals to the Workers' Compensation Division, Appellate Review Unit, PO Box 14480, Salem OR 97309-0405** **Or fax to: 503-947-7794** **Or hand-deliver to: Workers' Compensation Division, Appellate Review Unit, 350 Winter Street NE, 2nd Floor, Salem OR 97301** **You may appeal by phone by calling the Appellate Review Unit at 503-947-7816. A member of the Appellate Review Unit will complete and sign Form 2943 as the worker's designee and they will**	**If you disagree with this Notice of Refusal to Reclassify, you may appeal by contacting the Workers' Compensation Division. To appeal:** - **Contact the division within sixty (60) days of the mailing date of this notice.** - **You may use Form 2943, "Worker Request for Claim Classification Review," available on the division's website at wcd.oregon.gov.** - **Request review in writing or by phone.** **Send, hand deliver, or fax written requests to:** **Workers' Compensation Division** **Appellate Review Unit** **350 Winter Street NE, 2nd Floor** **PO Box 14480** **Salem OR 97309-0405** **Fax: 503-947-7794**

send a copy of the completed form to you, the insurer, and any attorneys involved in the claim.

If you do not appeal to the Workers' Compensation Division within 60 days of the mailing date of this notice, you will lose all rights to review of this decision. For assistance, you may call the Workers' Compensation Division at 503-947-7816, or the Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)."

Or, call the Workers' Compensation Division at 503-947-7816. The division will complete and sign Form 2943 on your behalf, and will send copies of the completed form to you, the insurer, and any attorneys involved in the claim.

If you do not appeal to the Workers' Compensation Division within 60 days of the mailing date of this notice, you will lose all rights to appeal this decision.

For help, call:

- **Workers' Compensation Division at 503-947-7816**
- **Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)**

OAR 436-060-0018(6)(a)(C)

Current, Grade 14:

"Notice to Worker: Your claim has been reclassified to nondisabling. Generally, this means your insurer concluded no disability payments are due and all of the following are true:

You were able to return to work at full wages on or before the fourth calendar day after leaving work or losing wages as a result of your injury.

You did not lose time or wages from work as a result of your injury on or after that fourth calendar day.

It appears you will not have any permanent disability as a result of your injury.

If you think there is a mistake in the classification of your claim as nondisabling, contact the insurer within one year of the date the insurer first accepted your claim and request reclassification.

If you request reclassification, the insurer must complete its review and send you its decision within 14 days of receiving your request. If you disagree with the insurer's decision, you have the right, within 60 days of the date of the insurer's notice, to request that the Workers' Compensation Division review your claim to determine if it was correctly classified. If the insurer does not respond to your request for reclassification within 14 days of receiving your request, you may ask the Workers' Compensation Division to review your claim as though the insurer refused to reclassify your claim. For assistance, you may call the Workers' Compensation Division at 503-947-7816,

Draft, revised, Grade 7:

Notice to worker:

We have changed your claim to nondisabling. Generally, this means no disability payments are due and all of the following are true:

- **You were able to return to work with full wages by the fourth calendar day after leaving work or losing wages because of your injury.**
- **You did not lose time or wages from work because of your injury on or after that fourth calendar day.**
- **It appears you will not have any permanent disability because of your injury.**

If you disagree that your claim is nondisabling, you may request that we change your claim to disabling.

- **You must send us your request in writing within one year of the date we first accepted your claim.**
- **We must review and send you our decision within 14 days of receiving your request.**

If you disagree with our decision, or we do not respond to your request, you have the right to appeal to the Workers' Compensation Division. To appeal:

or the Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)."	**- You must ask the division to review your claim within 60 days of the date we mailed you our decision.** **- If we did not respond within 14 days of receiving your request, ask the division to review your claim as if we refused to change your claim.** **For help, call:** **- Workers' Compensation Division at 503-947-7816** **- Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)**

OAR 436-060-0020(5)(b)

Current, Grade 8:	**Draft, revised, Grade 6:**
"You must attend this appointment. If there is any reason you cannot attend, you must tell us before the date of the appointment. If you do not attend, your temporary disability benefits will be suspended without further notice, as provided by ORS 656.262(4)(e)."	**You must attend this appointment. If there is any reason you can't attend, you must tell us before the date of the appointment. If you do not attend, your temporary disability benefits will be suspended without further notice under Oregon law.*** **If you have any questions you may call:** **- [Insurer] at 888-888-8888** **- Workers' Compensation Division at 1-800-452-0288** **- Ombuds Office for Oregon Workers at 1-800-927-1271** ***Oregon Revised Statute 656.262(4)(e)**

OAR 436-060-0020(5)(d)

Current, Grade 12:	**Draft, revised, Grade 8:**
"Since you missed a regular appointment with your doctor, we arranged a new appointment. We notified you of the new appointment by certified mail and warned you that your benefits would be suspended if you failed to attend. Since you failed to attend the new appointment, your temporary disability benefits have been suspended. In order to resume your benefits, you must schedule and attend an appointment with your doctor who must verify your continued inability to work."	**We have suspended your temporary disability benefits, because you missed a regular appointment with your doctor.** **When we arranged a new appointment for [Date], we notified you in a letter that was sent by certified mail.** **The letter warned you that we would suspend your benefits if you did not attend, and you did not attend the new appointment.** **To resume your benefits:** **- You must schedule and attend an appointment with your doctor, and**

- **Your doctor must verify that you are still unable to work.**

OAR 436-060-0030(3)(c)(G)

Current, Grade 14:

"If you refuse this offer of work for any of the reasons listed in this notice, you should write to the insurer or employer and tell them your reasons for refusing the job. If the insurer reduces or stops your temporary total disability and you disagree with that action, you have the right to request a hearing. To request a hearing you must send a letter objecting to the insurer's actions to the Worker's Compensation Board, 2601 25th Street SE, Suite 150, Salem, Oregon 97302-1282."

Draft, revised, Grade 4:

If you refuse this offer of work for any of the reasons listed in this notice, you should:

- **Write to the insurer or employer, and**
- **Tell them your reasons for refusing the job.**

If the insurer reduces or stops your temporary total disability, you may appeal by requesting a hearing. To request a hearing, send a letter objecting to the insurer's actions to:

Worker's Compensation Board
2601 25th Street SE, Suite 150,
Salem OR 97302-1282

OAR 436-060-0095(3)(d)(I)

Current, Grade 13:

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

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

Draft, revised, Grade 7:

You must attend this examination.

If there is any reason you can't attend, you must tell us as soon as possible before the date of the examination.

If you disagree with the location of this appointment, you must contact the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice.

Your workers' compensation benefits may be suspended under Oregon laws and rules* if you:

- **Do not attend the examination,**
- **Do not have a good reason for not attending the examination, or**
- **Do not cooperate with the examination.**

You may be charged a $100 penalty if you do not attend the examination without good reason or if you do not notify the insurer before the examination. The penalty is taken out of future benefits.

If you have any questions you may call:

- **[Insurer at 888-888-8888]**

	- **Workers' Compensation Division at 1-800-452-0288 or 503-947-7585** - **Ombuds Office for Oregon Workers at 1-800-927-1271.** ***Oregon Revised Statute 656.325 and Oregon Administrative Rule 436-060**

OAR 436-060-0095(6)(j)

Current, Grade 11:	**Draft, revised, Grade 7:**
"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. If the division grants this request, you may lose all or part of your benefits. If your claim has not yet been accepted, your future benefits, if any, will be jeopardized."	**Notice to worker:** **If the Workers' Compensation Division grants this request, you may lose all or part of current or future benefits.** **If you think this request to suspend your compensation is wrong, write to the Workers' Compensation Division immediately.** - **Your letter must be mailed within 10 days of the date this request was mailed or personally served on you.** - **Address your letter to:** **Workers' Compensation Division** **350 Winter Street NE** **PO Box 14480** **Salem OR 97309-0405** **If you have any questions, you may call the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585.**

OAR 436-060-0105(2)(d)

Current, Grade "post-graduate":	**Draft, revised, Grade 7:**
"If you continue to do insanitary or injurious acts beyond the date in this letter, or fail to consent to the medical or surgical treatment which is needed to help you recover from your injury, or fail to participate in physical rehabilitation needed to help you recover as much as possible from your injury, then we will request the suspension of your workers' compensation benefits. In addition, you may also have any permanent disability award reduced in accordance with ORS 656.325 and OAR 436-060."	**If you continue this inappropriate conduct after the above date:** - **We will ask that your workers' compensation benefits be suspended, and** - **Your permanent disability award, if any, may be reduced under ORS 656.325 and OAR 436-060.**

OAR 436-060-0105(4)(b)(G)

Current, Grade 16:	**Draft, revised, Grade 7:**
"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. If the division authorizes suspension of your compensation and you do not correct your unacceptable actions or show us a good reason why they should be considered acceptable, we will close your claim."	**Notice to worker:** **If the Workers' Compensation Division decides to suspend your benefits and you do not correct your unacceptable actions, or show us a good reason why they are acceptable, we will close your claim.** **If you think this request to suspend your benefits is wrong, write to the Workers' Compensation Division immediately.** **- Your letter must be mailed within 10 days of the date this request was mailed or personally served on you.** **- Address your letter to:** **Workers' Compensation Division** **350 Winter Street NE** **PO Box 14480** **Salem OR 97309-0405** **If you have any questions, you may call the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585.**

OAR 436-060-0105(5)(a)(D)

Current, Grade 11:	**Draft, revised, Grade 6:**
"Notice to worker: If you think this request to reduce your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the mailing date of this request. If the division grants this request, you may lose all or part of your benefits."	**Notice to worker:** **If the Workers' Compensation Division grants this request, you may lose all or part of your benefits.** **If you think this request to reduce your benefits is wrong, write to the Workers' Compensation Division immediately.** **- Your letter must be mailed within 10 days of the date this request was mailed or personally served on you.** **- Address your letter to:** **Workers' Compensation Division** **350 Winter Street NE** **PO Box 14480** **Salem OR 97309-0405**

	If you have any questions, you may call Workers' Compensation Division at 1-800-452-0288 or 503-947-7585.

OAR 436-060-0135(2)(a)(A)(iv)

Current, Grade "post-graduate":	**Draft, revised, Grade 7:**
"The workers' compensation law requires injured workers to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers are required to submit to and fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. If you do not reasonably cooperate with the investigation of this claim, payment of your compensation benefits may be suspended and your claim may be denied in accordance with ORS 656.262 and OAR 436-060."	**The law requires you to cooperate and assist in the investigation of your workers' compensation claim. This means you must take part and fully cooperate with:** **- Personal and telephone interviews, and** **- Other formal or informal information gathering techniques.** **If you do not reasonably cooperate:** **- Your workers' compensation benefit may be suspended, and** **- Your claim may be denied under ORS 656.262 and OAR 436-060.**

OAR 436-060-0137(3)(a)(G)

Current, Grade 13:	**Draft, revised, Grade 6:**
"You must attend this vocational evaluation. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the evaluation. If you do not attend or do not cooperate, or do not have a good reason for not attending, your compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.206 and OAR 436-060. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or the Ombuds Office for Oregon Workers at 1-800-927-1271."	**You must attend this evaluation.** **If there is any reason you cannot attend, you must tell us as soon as possible before the date of the evaluation.** **Your workers' compensation benefits may be suspended under Oregon laws and rules* if you:** **- Do not attend the evaluation,** **- Do not cooperate with the evaluation, or** **- Do not have good reason for not attending.** **If you have any questions you may call:** **- [Insurer] at 888-888-8888** **- Workers' Compensation Division at 1-800-452-0288 or 503-947-7585** **- Ombuds Office for Oregon Workers at 1-800-927-1271.** ***Oregon Revised Statute 656.206 and Oregon Administrative Rule 436-060**

OAR 436-060-0137(5)(b)(I)

Current, Grade 12:	**Draft, revised, Grade 6:**
"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. If the division grants this request, you may lose all or part of your benefits."	**Notice to worker:** **If the Workers' Compensation Division grants this request, you may lose all or part of your benefits.** **If you think this request to suspend your compensation is wrong, write to the Workers' Compensation Division immediately.** - **Your letter must be mailed within 10 days of the date this request was mailed or personally served on you.** - **Address your letter to:** **Workers' Compensation Division** **350 Winter Street NE** **PO Box 14480** **Salem OR 97309-0405** **If you have any questions, you may call:** - **[Insurer at 888-888-8888]** - **Workers' Compensation Division at 1-800-452-0288 or 503-947-7585** - **Ombuds Office for Oregon Workers at 1-800-927-1271.**

Options:

1) Revise notices (with additional edits based on advisory committee input)
2) Do not revise notices
3) Other

Fiscal Impacts, including cost of compliance for small business:
Insurers and self-insured employers may incur some near-term costs to revise letters and associated computer programs and templates. The agency does not have data that would allow projection of overall costs, but invites input from claims processors.

How will adoption of this rule affect racial equity in Oregon?
The Workers' Compensation Division does not collect data about race or ethnicity related to workplace injuries and illness in Oregon, but the United States Bureau of Labor Statistics publishes lists of occupations and numbers of Americans employed broken down by race.

Black/African American and Hispanic/Latino workers are represented in some of the more dangerous occupations in higher numbers than their respective shares of the U.S. workforce. To the extent Oregon workers in these racial groups suffer more on-the-job injuries and illnesses, streamlining of communications may benefit these racial groups more than others. The agency does not have sufficient data needed to estimate specific effects on racial equity in Oregon, but invites public input.

Recommendations:
Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Amber McMurry stated that the changes make the notices more understandable for the general population and makes the notices easier to read. She requested a reasonable amount of time for employers, insurers, etc. to update forms and templates.
- Elaine Schooler echoed Amber's concern regarding timing. She added that SAIF would like at least three months to update forms and templates and implement these changes. Elaine added that she noted the changed notice language aligned with varying reading levels: from grade four to grade eight. She noted that further simplification to get all notices on a standardized, uniform grade level—such as grade five or grade six—would be ideal.
- Thais Lomax noted a concern with those revisions in reference to suspension of temporary disability benefits. Specifically, she pointed out the language regarding a doctor verifying a worker is still unable to work (OAR 436-060-0020(5)(d)); she suggested it may be better to phrase it to say something like your doctor must objectively verify your current abilities to perform certain activities. She noted that, as it is broadly written, it negates any possible temporary disability options, return to work in modified capacity, etc.
- Keith Semple (via the chat) commented that Oregon Trial Lawyers agrees with the comments made about this issue.

Housekeeping issues

OAR 436-060-0005, 0015, 0020, 0170
Updating citations that reference Oregon Laws 2022.

OAR 436-060-0005(16)
Correcting a citation error. The rule currently states the definition of "regular wage" is in section (18) of the rule, when it is in section (19).

Minutes:

- Summer Tucker and Marie Rogers (Loiseau) closed the meeting by thanking all committee members for their participation and invited written comment to WCD.policy@dcbs.oregon.gov by the end of the day on Thursday, February 1, 2024.

Appendix

Revised mandatory notice wording with marked edits

OAR 436-060-0018(3)(b)(B)

"If you disagree with this Notice of Refusal to Reclassify, you may appeal by contacting the Workers' Compensation Division. To appeal:

- **Contact the division within sixty (60) days of the mailing date of this notice.**
- **You may ~~appeal by using~~use Form 2943, "Worker Request for Claim Classification Review," available on the division's website at wcd.oregon.gov.**
- **Request review in writing or by phone.**

Send, hand deliver, or fax written appeals to ~~the~~ :

Workers' Compensation Division
~~,~~Appellate Review Unit~~,~~
350 Winter Street NE, 2nd Floor
PO Box 14480
~~,~~Salem OR 97309-0405
~~Or fax to~~Fax: 503-947-7794

Or ~~hand-deliver to:~~, call the Workers' Compensation Division~~, Appellate Review Unit, 350 Winter Street NE, 2nd Floor, Salem OR 97301~~

~~You may appeal by phone by calling the Appellate Review Unit~~ at 503-947-7816. ~~A member of the Appellate Review Unit~~The division will complete and

sign Form 2943 ~~as the worker's designee~~on your behalf, and ~~they~~ will send ~~a copy~~copies of the completed form to you, the insurer, and any attorneys involved in the claim.

If you do not appeal to the Workers' Compensation Division within 60 days of the mailing date of this notice, you will lose all rights to ~~review of~~appeal this decision. ~~For assistance, you may call the Workers' Compensation Division at 503-947-7816, or the Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)."~~

For help, call:

- **Workers' Compensation Division at 503-947-7816**
- **Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free)**

OAR 436-060-0018(6)(a)(C)

"Notice to ~~Worker: Your~~ worker:

We have changed your claim ~~has been reclassified~~ to nondisabling. Generally, this means ~~your insurer concluded~~ no disability payments are due and all of the following are true:

- **You were able to return to work ~~at~~with full wages ~~on or before~~by the fourth calendar day after leaving work or losing wages ~~as a result~~because of your injury.**
- **You did not lose time or wages from work ~~as a result~~because of your injury on or after that fourth calendar day.**
- **It appears you will not have any permanent disability ~~as a result~~because of your injury.**

If you ~~think there~~disagree that your claim is ~~a mistake in the classification of your claim as~~ nondisabling, ~~contact the insurer~~you may request that we change your claim to disabling.

- **You must send us your request in writing within one year of the date ~~the insurer~~we first accepted your claim ~~and request reclassification~~.**
- **~~If you request reclassification, the insurer must complete its~~We must review and send you ~~its~~our decision within 14 days of receiving your request.**

If you disagree with ~~the insurer's~~our decision, or we do not respond to your request, you have the right~~,~~ to appeal to the Workers' Compensation Division.

To appeal:

- **You must ask the division to review your claim within 60 days of the date ~~of the insurer's notice, to request that the Workers' Compensation Division review your claim to determine if it was correctly classified. If the insurer does not respond to your request for reclassification~~we mailed you our decision.**
- **If we did not respond within 14 days of receiving your request, ~~you may~~ ask the ~~Workers' Compensation Division~~division to review your claim as ~~though the insurer~~if we refused to ~~reclassify~~change your claim.**

For ~~assistance, you may~~help, call ~~the~~ :

- **Workers' Compensation Division at 503-947-7816**
- **~~, or the~~ Ombuds Office for Oregon Workers at 503-378-3351 or 800-927-1271 (toll-free~~).~~")**

OAR 436-060-0020(5)(b)

"You must attend this appointment. If there is any reason you ~~cannot~~can't attend, you must tell us before the date of the appointment. If you do not attend, your temporary disability benefits will be suspended without further notice~~, as provided by ORS 656.262(4)(e)."~~ under Oregon law.*

If you have any questions you may call:

- **[Insurer] at 888-888-8888**
- **Workers' Compensation Division at 1-800-452-0288**
- **Ombuds Office for Oregon Workers at 1-800-927-1271**

***Oregon Revised Statute 656.262(4)(e)**

OAR 436-060-0020(5)(d)

"~~Since~~We have suspended your temporary disability benefits, because you missed a regular appointment with your doctor~~,~~.

When we arranged a new appointment~~. We~~ for [Date], we notified you ~~of the new appointment~~in a letter that was sent by certified mail ~~and~~.

The letter warned you that ~~your benefits~~we would ~~be suspended~~ suspend your benefits if you ~~failed to~~did not attend~~. Since~~, and you ~~failed to~~did not attend the new appointment~~, your temporary disability benefits have been suspended. In order to~~.

To resume your benefits~~, you~~:

- **You must schedule and attend an appointment with your doctor ~~who~~, and**
- **Your doctor must verify ~~your continued inability~~that you are still unable to work~~."~~.**

OAR 436-060-0030(3)(c)(G)

~~"~~If you refuse this offer of work for any of the reasons listed in this notice, you should ~~write~~:

- **Write to the insurer or employer, and ~~tell~~**
- **Tell them your reasons for refusing the job.**

If the insurer reduces or stops your temporary total disability ~~and~~, you ~~disagree with that action, you have the right to~~may appeal by requesting a hearing. To request a hearing ~~you must~~, send a letter objecting to the insurer's actions to ~~the~~ :

Worker's Compensation Board
~~,~~2601 25th Street SE, Suite 150,
Salem~~, Oregon~~ OR 97302-1282~~."~~

OAR 436-060-0095(3)(d)(I)

~~"~~You must attend this examination.

If there is any reason you ~~cannot~~can't attend, you must tell ~~the insurer~~us 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~~disagree with the ~~examination, your workers' compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.325 and OAR 436-060. You may be charged a $100 penalty if you fail to attend without a good reason or if you fail to notify the insurer before the examination. The penalty is taken out of future benefits.~~

~~If you object to the~~ location of this appointment, you must contact the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice. ~~If you have questions about your rights or~~

~~responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 or the Ombuds Office for Oregon Workers at 1-800-927-1271."~~

Your workers' compensation benefits may be suspended under Oregon laws and rules* if you:

- Do not attend the examination,
- Do not have a good reason for not attending the examination, or
- Do not cooperate with the examination.

You may be charged a $100 penalty if you do not attend the examination without good reason or if you do not notify the insurer before the examination. The penalty is taken out of future benefits.

If you have any questions you may call:

- [Insurer at 888-888-8888]
- Workers' Compensation Division at 1-800-452-0288 or 503-947-7585
- Ombuds Office for Oregon Workers at 1-800-927-1271.

*Oregon Revised Statute 656.325 and Oregon Administrative Rule 436-060

OAR 436-060-0095(6)(j)

"**Notice to worker:**

If the Workers' Compensation Division grants this request, you may lose all or part of current or future benefits.

If you think this request to suspend your compensation is wrong, ~~you should immediately~~ write to the Workers' Compensation Division~~, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405.~~ immediately.

- **Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. ~~If the division grants this request, you may lose all or part of your benefits. If your claim has not yet been accepted, your future benefits, if any, will be jeopardized."~~**
- Address your letter to:

  Workers' Compensation Division
  350 Winter Street NE
  PO Box 14480
  Salem OR 97309-0405

If you have any questions, you may call the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585.

OAR 436-060-0105(2)(d)

~~"~~If you continue ~~to do insanitary or injurious acts beyond~~this inappropriate conduct after the above date ~~in this letter, or fail to consent to the medical or surgical treatment which is needed to help you recover from your injury, or fail to participate in physical rehabilitation needed to help you recover as much as possible from your injury, then we~~:

- **~~We~~ will ~~request the suspension of~~ask that your workers' compensation benefits~~. In addition, you may also have any~~ be suspended, and**
- **Your permanent disability award~~, if any, may be~~ reduced ~~in accordance with~~under ORS 656.325 and OAR 436-060~~."~~.**

OAR 436-060-0105(4)(b)(G)

~~"~~Notice to worker:

If the Workers' Compensation Division decides to suspend your benefits and you do not correct your unacceptable actions, or show us a good reason why they are acceptable, we will close your claim.

If you think this request to suspend your ~~compensation~~benefits is wrong, ~~you should immediately~~ write to the Workers' Compensation Division~~, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405.~~ immediately.

- **Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. ~~If the division authorizes suspension of your compensation and you do not correct your unacceptable actions or show us a good reason why they should be considered acceptable, we will close your claim."~~**
- **Address your letter to:**

  Workers' Compensation Division
  350 Winter Street NE
  PO Box 14480
  Salem OR 97309-0405

If you have any questions, you may call the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585.

OAR 436-060-0105(5)(a)(D)

"Notice to worker:

If the Workers' Compensation Division grants this request, you may lose all or part of your benefits.

If you think this request to reduce your ~~compensation~~benefits is wrong, ~~you should immediately~~ write to the Workers' Compensation Division~~, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405.~~ immediately.

- **Your letter must be mailed within 10 days of the ~~mailing~~ date ~~of~~ this request~~. If the division grants this request,~~ was mailed or personally served on you~~ may lose all or part of your benefits."~~.**
- **Address your letter to:**

  Workers' Compensation Division
  350 Winter Street NE
  PO Box 14480
  Salem OR 97309-0405

If you have any questions, you may call Workers' Compensation Division at 1-800-452-0288 or 503-947-7585.

OAR 436-060-0135(2)(a)(A)(iv)

"The ~~workers' compensation~~ law requires ~~injured workers~~ you to cooperate and assist ~~the insurer or self-insured employer~~ in the investigation of ~~claims for~~your workers' compensation~~. Injured workers are required to submit to~~ claim. This means you must take part and fully cooperate with ~~personal~~:

- **Personal and ~~telephonic~~telephone interviews, and ~~other~~**
- **Other formal or informal information gathering techniques.**

If you do not reasonably cooperate ~~with the investigation of this claim, payment of your~~:

- **Your workers' compensation ~~benefits~~benefit may be suspended, and ~~your~~**
- **Your claim may be denied ~~in accordance with~~under ORS 656.262 and OAR 436-060~~."~~.**

OAR 436-060-0137(3)(a)(G)

"You must attend this ~~vocational~~ evaluation.

If there is any reason you cannot attend, you must tell ~~the insurer~~us as soon as possible before the date of the evaluation. ~~If~~

Your workers' compensation benefits may be suspended under Oregon laws and rules* if you ~~do~~:

- **Do not attend ~~or do~~the evaluation,**
- **Do not cooperate with the evaluation, or ~~do~~**
- **Do not have ~~a~~ good reason for not attending~~, your compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.206 and OAR 436-060. .~~**

If you have any questions ~~about your rights or responsibilities,~~ you may call ~~the~~ :

- **[Insurer] at 888-888-8888**
- **Workers' Compensation Division at 1-800-452-0288 or ~~the~~ 503-947-7585**
- **Ombuds Office for Oregon Workers at 1-800-927-1271~~."~~.**

***Oregon Revised Statute 656.206 and Oregon Administrative Rule 436-060**

~~"~~Notice to worker:

OAR 436-060-0137(5)(b)(I)

If the Workers' Compensation Division grants this request, you may lose all or part of your benefits.

If you think this request to suspend your compensation is wrong, ~~you should immediately~~ write to the Workers' Compensation Division~~, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405.~~ immediately.

- **Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. ~~If the division grants this request, you may lose all or part of your benefits."~~**
- **Address your letter to:**

Workers' Compensation Division

350 Winter Street NE

PO Box 14480

Salem OR 97309-0405

If you have any questions, you may call:

- **[Insurer at 888-888-8888]**
- **Workers' Compensation Division at 1-800-452-0288 or 503-947-7585**
- **Ombuds Office for Oregon Workers at 1-800-927-1271.**