Agenda

Rulemaking Advisory Committee

Workers' Compensation Division Rules,

- **OAR 436-060, Claims Administration**

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	September 10, 2025 1:30 – 4:30 p.m. Labor & Industries Building, 350 Winter St NE, Salem, Room F (basement) Or via Microsoft Teams: https://teams.microsoft.com/l/meetup-join/19%3ameeting_N2FkNDFkNjMtMWMxNC00ZjUxLThhNjQtNjdmMjFmYWY5Yzc3%40thread.v2/0?context=%7b%22Tid%22%3a%22aa3f6932-fa7c-47b4-a0ce-a598cad161cf%22%2c%22Oid%22%3a%22419bb41f-34a1-4d77-8afc-abd87db857e0%22%7d Meeting ID: 281 437 887 787 0 Passcode: vr7Mz3Kb **Dial in by phone** +1 503-446-4951,,863188684# Phone conference ID: 863 188 684#
Facilitators:	Marie Rogers, Summer Tucker, Workers' Compensation Division
1:30 to 1:40	Welcome and introductions; meeting objectives
1:40 to 3:00	Discussion of issues – see attachment.
3:00 to 3:15	Break
3:15 to 4:15	Discussion of issues on agenda continued.
4:15 to 4:30	Summing up – next steps – thank you!

Attached: OAR 436-060 Issues Document

Oregon Administrative Rule Revision
Chapter 436, Division 60

Issues Document

Rulemaking Advisory Committee Meeting
September 10, 2025

Issue # & link	Subject	Rule(s)
Issue 1	HB 2802 rule revision – Division 60	0060
Issue 2	HB 2802 rule revision – Division 30	0135
Issue 3	Timeframe to submit a request to suspend worker benefits	0095 0105 0135 0137
Issue 4	COVID claim investigation requirements and audit provisions	0141
Issue 5	Misdirected claims process	0011
Issue 6	Modified and updated notices of acceptance	0140
Issue 7	Weekly wage calculation – fluctuating overtime pay rate	0025
Issue 8	Weekly wage calculation – sign on and relocation bonuses	0025
Issue 9	Weekly wage calculation – no wages in the 52 weeks before the date of injury.	0025
Issue 10	Post injury wages	0030
Issue 11	Temporary partial disability when a modified job no longer exists or an offer is withdrawn, and there are post-injury wages	0030
Issue 12	End date of permanent total disability benefits – Divisions 60 and 75	060-0075 075-0030
Issue 13	Penalty due date when a stipulation is appealed	0155
Issue 14	Civil penalty provisions	0200
Issue 15	Settlement agreements related to supplemental disability benefits	0500
Issue 16	Worker Requested Medical Exams	0147
Housekeeping	• Correcting grammar and clarifying wording • Removing obsolete mandatory notice language • Modifying instances where “appeal” is used to refer to a review by the Workers’ Compensation Division or Board	

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Rule: OAR 436-060-0060, Lump Sum Payment of Permanent Partial Disability Awards

Issue: The rule regarding lump sum payments of permanent partial disability must be updated to align with revisions to ORS 656.230 under House Bill 2802 (2025).

Background:
When an insurer issues a notice of closure, the worker may be awarded permanent partial disability (PPD). Following the closure, the PPD award may be paid to the worker in monthly installments, or the worker may request the award be paid in a lump sum. ORS 656.230 outlines when the insurer must pay the award in a lump sum, and OAR 436-060-0060 closely follows wording and structure of that statute.

House Bill 2802 (2025) recently amended ORS 656.230. The bill modified the circumstances where the insurer is required to pay a PPD award in a lump sum, and altered the structure of the statute. The bill will go into effect on January 1, 2026.

The division has reviewed the current wording of OAR 436-060-0060 and determined that revisions are needed to ensure the rule is consistent with the statute. The division invites input on the proposed revisions.

Options
1) Revise OAR 436-060-0060 and OAR 436-060-0003 as follows.

OAR 436-060-0060 Lump Sum Payment of Permanent Partial Disability Awards
(1) General.
When an award for permanent partial disability is $6,000 or less, the insurer must pay the total amount of the award to the worker in a lump sum payment. When the total amount of the award for permanent partial disability exceeds $6,000, the worker or worker's attorney may request a lump sum payment of all or part of the award.

(a) Subject to subsection (b) of this section, if the worker or worker's attorney has requested a lump sum payment of an award where the total amount of the award exceeds $6,000, ~~T~~the insurer must make the payment requested if:

(A) The worker has waived the right to request reconsideration of the notice of closure; or

(B) The award has become final by operation of law.

(b) The insurer is not required to make the payment requested if:

(A) The insurer or self-insured employer timely requests reconsideration of the notice of closure under ORS 656.268(5)(e) and the reconsideration proceeding has not yet been completed;

~~may only deny the request for lump sum payment if any of the following apply:~~
~~(a) The worker has not waived the right to appeal the adequacy of the award;~~

~~(b) The award has not become final by operation of~~ (Bc) The payment of compensation has been stayed pending a request for hearing or review under ORS 656.313; or

(C~~d~~) The worker is enrolled and actively engaged in an authorized training plan under OAR 436-120. For dates of injury before Jan. 1, 2005, the insurer may not approve a request for lump sum payment of unscheduled permanent disability. For dates of injury on or after Jan. 1, 2005, the insurer may not approve a request for lump sum payment of work disability when the worker:

(i~~A~~) Has been found eligible for an authorized training plan under OAR 436-120 and will start the plan within 30 days of the date of the decision on the lump sum payment request;

(ii~~B~~) Is actively enrolled and engaged in an authorized training plan under OAR 436- 120; or

(iii~~C~~) Has temporarily withdrawn from an authorized training plan under OAR 436- 120.

OAR 436-060-0003 Purpose, Applicability, Forms, and Bulletins
(2) Applicability.
(a) The rules are subject to the applicability provisions under ORS 656.202.
(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.
(c) OAR 436-060-0060(1), as adopted by WCD Administrative Order XX-XXXX, effective January 1, 2026, applies to claims in which a notice of closure is issued on or after January 1, 2026.

2) Other

Fiscal impacts, including cost of compliance for small business:
No significant impacts are expected. Insurers, self-insured employers, and service companies may need to slightly adjust their processes to align with the law, but the law has not changed drastically. The division invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in when lump sum payments are available may impact 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.

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Rule: OAR 436-030-0135(4), Reconsideration Procedure

Issue: Reconsideration proceedings are limited when a worker requests and cashes a lump sum payment of permanent partial disability. The current limitations need to be updated to align with revisions to ORS 656.230 under House Bill 2802 (2025).

Background:
When an insurer issues a notice of closure, the worker may be awarded permanent partial disability (PPD). Following the closure, the worker may request the award be paid in a lump sum. Insurers either approve or deny the request. If the lump sum payment is denied, the worker still receives the award in installment payments.

ORS 656.230 currently provides that if a worker requests a lump sum payment of their PPD award, the insurer must make a lump sum payment, unless any of the following conditions apply:

(a) The worker has not waived the right to appeal the adequacy of the PPD award.

(b) The award is not final by operation of law.

(c) Payment of compensation has been stayed pending a request for hearing or review under ORS 656.313.

(d) The worker is enrolled and actively engaged in vocational training.

The wording in (a) implies a worker can receive a lump sum payment if they waived the right to appeal the adequacy of the PPD award. However, an insurer may opt to deny the payment if the award is not final by operation of law, based on (b).

In general, if the worker disagrees with the amount of a PPD award or another aspect of the notice of closure, they may request reconsideration by the division. But, in cases where the worker has requested and cashed a lump sum payment, OAR 436-030-0135(4) limits what topics will be considered in the reconsideration proceeding, stating:

> "When a worker has requested and cashed a lump sum payment, under ORS 656.230, of an award granted by a Notice of Closure, the director will not consider the adequacy of that award in a reconsideration proceeding."

This rule currently aligns with ORS 656.230 by limiting what issues will be considered in a reconsideration, if the worker waived the right to appeal the adequacy of the PPD award. The amount of the PPD award could not be appealed, but other issues related to a notice of closure could be raised (e.g., a dispute regarding the medically stationary date).

House Bill 2802 (2025) amended ORS 656.230, and will be effective January 1, 2026. ORS 656.230 changes the structure of the statute and specifies the circumstances when a lump sum payment is required. Under HB 2802, the insurer must make a lump sum payment if the worker "…has waived the right to request reconsideration of the notice of closure;" or if the award is

final by operation of law. If the worker wants to keep the right to request reconsideration, they will still receive the award in installments instead of a lump sum payment. However, the option to waive rights under HB 2802 is different compared to current law. HB 2802 requires a broader waiver compared to current law, because it includes the amount of the PPD award *and* other issues related to the notice of closure.

Under HB 2802, if a worker receives a lump sum payment because they waived the right to request reconsideration of a notice of closure, there should not be any issues to raise regarding the notice of closure in a reconsideration proceeding. This renders OAR 436-030-0135(4) inconsistent with statute, since the rule indicates notice of closure issues that are not related PPD could be considered, based on current law.

To ensure the reconsideration process is aligned with the amendments to ORS 656.230, the division has determined that OAR 436-030-0135(4) should be revised. The division invites input on the following options.

Options

1) Revise OAR 436-030-0135(4) and OAR 436-030-0003(2) as follows.

OAR 436-030-0135 Reconsideration Procedure

(4) If the notice of closure was issued on or after Jan. 1, 2026, ~~W~~when a worker has requested ~~and cashed~~ a lump sum payment~~, under ORS 656.230,~~ of a permanent partial disability~~n~~ award granted by a Notice of Closure under ORS 656.230, waived the right to request reconsideration of the Notice of Closure, and cashed the lump sum payment, the director will not conduct~~sider the adequacy of that award in~~ a reconsideration proceeding.

OAR 436-030-0003 Purpose, Applicability, Forms, and Bulletins

(2) Applicability of rules.

(a) Except as provided in subsections (c) and (d) of this section, the rules in OAR 436-030 apply to all accepted claims for workers' compensation benefits and all claims closed on or after the effective date of these rules.

(b) All orders the division issues to carry out the statute and the rules in OAR 436-030 are considered orders of the director.

(c) For claims in which the worker became medically stationary before July 2, 1990, OAR 436-030-0020, 436-030-0030, and 436-030-0050 as adopted by WCD Administrative Order 13-1987, effective January 1, 1988, will apply.

(d) OAR 436-030-0055(3)(b), (3)(d), and (4)(a) apply to all claims with dates of injury on or after January 1, 2002.

(e) OAR 436-030-0135(2), as adopted by WCD Administrative Order XX-XXXX, effective January 1, 2026, applies to claims in which a notice of closure is issued on or after January 1, 2026.

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

2) Other

Fiscal impacts, including cost of compliance for small business:
No significant impacts are expected, this does not change the amount of permanent disability the insurer initially awards on a notice of closure. Insurers, self-insured employers, and service companies may need to slightly adjust their processes to align with the law. The division invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in when lump sum payments are available may impact 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.

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Rule: OAR 436-060-0095, Medical Examinations; Suspension of Compensation; and Independent Medical Examination Notice

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

OAR 436-060-0135, Injured Worker, Worker's Attorney Responsible to Assist in Investigation; Suspension of Compensation and Notice to Worker

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

Issue: A stakeholder submitted a rule issue to the division regarding the wording of "any delay" in OAR 436-060-0095. Because the rule does not define what is considered a delay, the stakeholder noted it could lead to confusion and inconsistency.

Background:
Under OAR 436-060-0095, the insurer may require a worker to attend an independent medical examination (IME). If the worker does not attend the IME, the insurer may submit a request to the division to authorize suspending the worker's benefits. However, OAR 436-060-0095(7) specifies that if there is "any delay" in requesting authorization, the division may deny or modify the date of the authorization. If authorized, the date of the authorization is the date the worker fails to attend the examination or another date the division deems appropriate.

This provision for denying authorization to suspend a worker's benefits when there is "any delay" in an insurer's request is included in other rules as well:

- When the worker commits insanitary or injurious practices. OAR 436-060-0105(4)(c).
- When the worker does not cooperate with the insurer's investigation of the claim. OAR 436-060-0135(4).
- When the worker does not attend a vocational evaluation for permanent total disability benefits. OAR 436-060-0137(5)(d).

A stakeholder submitted a rule issue to the division regarding the wording of "any delay" in OAR 436-060-0095(7). Because the rule does not define what is considered a delay, the stakeholder noted it could lead to confusion and inconsistency. They recommended that the rule provide a specific number of days for the insurer to send their request to the division, potentially 21 or 30 days from the date of the missed IME.

It is the division's policy to deny a suspension request under OAR 436-060-0095(7) if the insurer submits the request more than 21 days after the date the worker missed the IME. Though, there are times where there will be an exception based on the facts of the case. This 21 day timeframe is also applied in other rules where the division authorizes suspension of benefits.

Although the division already has a policy about what constitutes a delay, the division is considering codifying current practice in rule so it is clear how much time an insurer has to

submit a request before it is considered delayed. However, because the circumstances may vary, the division believes it is necessary to maintain some discretion in the rule, for unique cases where a delayed request may be reasonable.

The division seeks input on the following:

- When a request for suspension following a missed IME should be considered delayed.
- Whether this issue should be addressed in any of the other three suspension scenarios noted below. The division's current practice for the other scenarios is noted below.

Missing a vocational evaluation for permanent total disability benefits	These suspension requests are extremely rare, but if the division received one, the division would consider denying the request if submitted 21 days or more after the worker misses a vocational evaluation.
Noncooperation with the insurer's claim investigation	The division typically denies suspension requests submitted 21 days or more after the deadline specified in a written notice the insurer sends to the worker. (The written notice is required under OAR 436-060-0135(2).)
Insanitary or injurious practices	The division considers two factors to determine whether a suspension request was delayed and should be denied. The first is the deadline specified in the insurer's written notice to the worker, which states the date to stop inappropriate actions or the date by which compliance is expected. (The written notice is required under OAR 436-060-0105(2).) The second is what the worker was asked to do in the written notice. For some requirements, the time it takes for the worker to comply may vary and not be immediate (e.g., the notice may require the worker to quit smoking, or lose weight for a surgery).

Options:

1) Amend OAR 436-060-0095(7) to state a suspension request may be considered delayed if sent to the division 21 days or more after the IME, and that at the director's discretion, a request could be considered delayed at any point in time.

OAR 436-060-0095(7)
"(7) Effective date of suspension.
If the director authorizes the suspension of compensation, the suspension will be effective from the date the worker fails to attend an examination or such other date the director deems appropriate until the date the worker undergoes an examination scheduled by the insurer or director. Any delay in requesting consent for suspension may result in authorization being denied or the date of authorization being modified. A request may be

considered delayed if sent to the director 21 days or more after the date the worker fails to attend an examination, or such other date the director deems appropriate. However, at the director's discretion, a request may be considered delayed at any point in time."

2) Amend OAR 436-060-0137(5) to state a suspension request may be considered delayed if sent to the division 21 days or more after the vocational evaluation, and that at the director's discretion, a request could be considered delayed at any point in time.

OAR 436-060-0137(5)(d)
(5) Suspension of compensation
When the worker refuses or fails to attend, or otherwise obstructs, a vocational evaluation reasonably requested by the insurer or the director, the director may suspend the worker's compensation by order, under the following conditions:

[(a)–(c) omitted]

(d) If the insurer fails to comply with this rule, the director may deny the request for suspension. Any delay in requesting suspension may result in suspension being denied or the date of suspension being modified. A request may be considered delayed if sent to the director 21 days or more after the date the worker refuses or fails to attend or otherwise obstructs a vocational evaluation, or such other date the director deems appropriate. However, at the director's discretion, a request may be considered delayed at any point in time; and

[(e) omitted]

3) Amend OAR 436-060-0105(4)(c) to state a suspension request may be considered delayed if sent to the division 21 days or more after the date specified in the insurer's written notice to the director, and that at the director's discretion, a request could be considered delayed at any point in time.

(4) Request for suspension of benefits.
The insurer must verify whether the worker complied with the request for cooperation on the date specified in subsection (2)(c) of this rule. If the worker initially agrees to comply, or complies and then refuses or fails to continue doing so, the insurer is not required to send further notice before requesting suspension of compensation.

[(a)–(b) omitted]

(c) Any delay in obtaining confirmation or in requesting the suspension of compensation may result in authorization being denied or the date of authorization being modified by the date of actual confirmation or the date the request is received by the division. A request may be considered delayed if sent to the director 21 days or more after the date specified under (2)(c) of this rule, or such other date the director deems appropriate. However, at the director's discretion, a request may be considered delayed at any point in time.

4) Amend OAR 436-060-0135(4) to state a suspension request may be considered delayed if sent to the division 21 days or more after the date specified in the insurer's written notice to the director, and that at the director's discretion, a request could be considered delayed at any point in time.

> (4) Failure to comply with this rule.
> Failure to comply with the requirements of this rule will be grounds for denial of the insurer's request. Any delay in requesting suspension under section (2) of this rule may result in authorization being denied. A request may be considered delayed if sent to the director 21 days or more after the date specified under (2)(a)(A)(i), or such other date the director deems appropriate. However, at the director's discretion, a request may be considered delayed at any point in time.

5) No change.
6) Other

Fiscal impacts, including cost of compliance for small business:
No impacts are expected, but the division invites input from advisory committee members about costs, including costs to be borne by small businesses, and impact on racial equity.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in when workers' compensation benefits may be suspended may impact 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.

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Rule: OAR 436-060-0141, Claims for COVID-19 or Exposure to SARS-CoV-2

Issue: The rule governing the processing of claims for COVID-19 or exposure to SARS-CoV-2 is inconsistent with current public health recommendations and is outdated. Additionally, since the number of COVID claims has decreased significantly, the rule may no longer be necessary.

Background:
OAR 436-060-0140(1) requires insurers to conduct a reasonable investigation before denying a claim. Under this rule, a reasonable investigation is whatever steps a reasonably prudent person with knowledge of the legal standards for determining compensability would take in a good faith effort to ascertain the facts underlying a claim, giving due consideration to the cost of the investigation and the likely value of the claim.

Additional investigation requirements have been established under OAR 436-060-0141, which was adopted to promote appropriate and consistent processing of claims for COVID-19 or exposure to SARS-CoV-2 during the public health emergency in 2020. Those additional requirements include:

- Investigate whether there was likely exposure to COVID-19 or SARS-CoV-2 that arose out of and in the course of the worker's employment.

- Before issuing a compensability denial, investigate the source of the worker's exposure to COVID-19 or SARS-CoV-2, which must include obtaining a medical or expert opinion, if:
    - The worker tests positive for COVID-19; or
    - A medical service provider diagnoses a presumptive case of COVID-19, the insurer is aware of the test results or presumptive diagnosis, and the source of the exposure is unclear.

- Determine whether the worker did not work for a period of quarantine or isolation at the direction of a medical service provider, the Oregon Health Authority Public Health Division, a local public health authority as defined in ORS 431.003, or the employer, for purposes of discovering information that may be relevant to the compensability determination.

- Determine whether medical services were required as a result of potential workplace exposure to COVID-19 or SARS-CoV-2, even if the worker ultimately did not test positive for COVID-19.

Since OAR 436-060-0141 was adopted in 2020, public health recommendations and COVID testing approaches have changed, and it appears that the rule is no longer consistent with current recommendations or practice.

- The rule requires getting a medical or expert opinion if the worker tests positive for COVID. Today, at home COVID tests are more widely available and workers may not need to go a medical provider for a test.
- The rule requires getting a medical or expert opinion if a medical service provider diagnoses a presumptive case of COVID, the insurer is aware of the test results or presumptive diagnosis, and the source of exposure is unclear. Since COVID tests are more widely available, it may be less likely that providers are diagnosing presumptive cases.
- The rule requires determining if the worker did not work for a period of quarantine or isolation at the direction of a medical service provider, the Oregon Health Authority Public Health Division, a local public health authority, or the employer. However, the Oregon Health Authority and Centers for Disease Control no longer recommend isolating for a set number of days, and instead recommend staying home until certain symptoms stop for at least 24 hours.

Additionally, OAR 436-060-0141 states when the director will audit denied claims for COVID or exposure to COVID. However, based on audit data and the frequency of COVID claims, a rule outlining the steps of a reasonable investigation and when the Workers' Compensation Division (division) will audit claims may not be necessary.

- Following adoption of the rule, the division conducted two audits of denied COVID-19 claims in 2021 and 2022. The 2021 audit reviewed insurer compliance with the general reasonable investigation standards in OAR 436-060-0140. The 2022 audit was based on the COVID-specific standards. In both audits, the division found reasonable investigations were conducted in all claims reviewed.
- Though the rule establishes that the division will conduct an audit of denied claims, a rule is not required in order for the division to conduct an audit. If OAR 436-060-0141 were repealed, the division still has authority to conduct audits based on the general standards for reasonable investigations under in OAR 436-060-0140.
- The number of claims filed for COVID or exposure to COVID has significantly declined since 2020. Claim data reported to the division[1] indicates that in 2024, 160 claims were filed, compared to 2,779 in 2020. As of July 6, 2025, only five claims have been filed for 2025.

[1] Source: Oregon Department of Consumer and Business Services, Central Services Division July 6, 2025
Note: The data is based on accepted disabling, denied disabling, and denied nondisabling workers' compensation claims. The data does not include accepted nondisabling claims. Insurers are not required to report accepted nondisabling claims to the division.

COVID related claims 2020 - 2025	
Year	**Count of Claims**
2020	2,779
2021	2,425
2022	3,277
2023	802
2024	160
2025	5

Given the changes in public health recommendations and fewer COVID claims, the division is considering whether OAR 436-060-0141 should be repealed or revised. The division requests input on the following:

- Should the rule be updated, and if so, what areas should be updated?
- Are there elements of the rule that still need to be in place? If so, should those elements remain COVID specific?
- Are there elements of the rule that could be generalized or may already be covered by another rule?
- Should the rule be repealed?

Options
To be determined based on stakeholder feedback**.**

Fiscal Impacts, including cost of compliance for small business:
Impact is unknown, though if the rule is repealed, it may reduce costs if investigations include steps that are no longer necessary. The division invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in workers' compensation benefits or processes may impact 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.

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Rule: OAR 436-060-0011, Insurer Reporting Requirements

Issue: When a claim is sent to the wrong insurer, the receiving insurer may send it to the correct insurer, or the division. Misdirected claims sent to the division when the correct insurer is known causes delays for the correct insurer to start processing the claim and providing benefits.

Background:
OAR 436-060-0011(2) directs insurers on what to do if a claim is mistakenly sent to them and they did not provide coverage for the worker's employer. The rule provides insurers two options: send the misdirected claim to the correct insurer directly, or forward it to the division. Either way, the insurer must forward the claim within three days of the date it determined it was not responsible for the claim.

If the insurer has determined they are not the insurer for the claim, it is likely that they have determined who the correct insurer is during that investigation. However, the division has found that sometimes misdirected claims are sent to the division when it appears the receiving insurer identified the correct insurer. In those cases, the claim has been sent to the division with an attached print out from the division's online proof of coverage search tool, showing the correct insurer and their contact information, or other evidence that shows where the claim belongs. The division has also received misdirected claims that the division ended up sending back to the receiving insurer, because the division found that they truly were the correct insurer.

It is compliant with the rule to send a misdirected claim to the division. However, forwarding the claim indirectly by sending to the division delays when the correct insurer will receive the claim and can start processing the claim to provide worker benefits.

The division is aware it may be difficult to determine the correct insurer (e.g., complex coverage situations like a wrap up policy, or if there's confusion about the worker's employer). In those cases, the division wants to ensure insurers are still able to forward misdirected claims to the division, to ensure the claim gets to the right insurer. The division encourages insurers to continue to contact the division when coverage is unclear or assistance is needed in finding coverage. However, for the cases where the correct insurer is evident, the division is concerned that the current rule allows for unnecessary delay of benefits and claim processing by allowing the insurer to send the claim to the division instead of the correct insurer.

Anecdotally, division staff have observed the volume of misdirected claims varies. In general, insurers forward claims to the correct insurer once identified. However, there have been periodic increases of misdirected claims that are sent to the division instead, which may cause delays in benefits to workers. When there have been increases, division outreach to the senders temporarily alleviates the issue.

The division does not have data available on how frequently a misdirected claim could have been sent directly to the correct insurer instead of the division. Nonetheless, because the underlying rule may build in some delay in workers receiving benefits and in claim processing, the division believes it is important to discuss how the rule could be revised to ensure workers receive

benefits promptly. To that end, the division is considering amending the rule to require insurers to forward misdirected claims directly to the correct insurer, and invites input on the following options.

Options

1) Amend OAR 436-060-0011(2) to require the receiving insurer to send the claim directly to the correct insurer, if they have determined who the correct insurer is. If it cannot be determined who the correct insurer is, the receiving insurer must send the claim to the division.

2) No change.

3) Other.

Fiscal Impacts, including cost of compliance for small business:
The fiscal impact is not determined yet, and will depend on stakeholder feedback. The division does not have data to estimate the fiscal impact, but invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in how quickly a worker's claim is processed may impact 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.

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Rule: OAR 436-060-0140, Acceptance or Denial of a Claim, and
OAR 436-030-0015, Insurer Responsibility

Issue: The rules do not address whether a modified notice of acceptance may be combined with an updated notice of acceptance.

Background:
When a claim is accepted, the insurer may issue three different types of notices confirming or modifying the acceptance over the course of a claim. OAR 436-060-0140 states when these notices must be issued, and what information must be included in a notice of acceptance.

Initial Notice of Acceptance (INOA)	The first notice issued.
Modified Notice of Acceptance (MNOA)	Follows an INOA and issued if certain events occur (e.g., the insurer adds more conditions, changes the disability status, accepts an aggravation claim, or amends a previous notice of acceptance.)
Updated Notice of Acceptance at Closure (UNOA)	Issued at the end of the claim on the same date as the Notice of Closure. Lists all compensable conditions, and any conditions under appeal

Additionally, OAR 436-030-0015 describes in more detail what information must be included in an UNOA.

In general, the INOA and UNOA are issued separately; however, OAR 436-030-0015(1)(c)(C) indicates an INOA may be combined with a UNOA. This rule provides if an INOA is issued at the same time as the UNOA, both titles must appear near the top of the document.

The division has periodically received and discussed questions about whether a MNOA and UNOA may be combined. In contrast to an INOA and UNOA, neither OAR 436-060 or 436-030 address whether a MNOA and UNOA may be combined. The division's rulemaking records do not indicate why MNOAs were not included when OAR 436-030-0015(1)(c)(C) was established in 1998. However, when the rule was written, MNOAs were not mentioned in OAR 436-030 or 436-060. Later revisions of OAR 436-060 added references to MNOAs, but did not include any language to combine a MNOA and UNOA.

The division is considering whether OAR 436-060 should include a provision that allows combining the MNOA and UNOA. Addressing this issue in rule would reduce any confusion about whether combining is allowed, and be consistent with the existing rule that allows combining a INOA and UNOA. It would also more allow for streamlining the amount of notices sent to the worker. Streamlining could be helpful when accepted conditions need to be modified or added just before the claim is closed, or when the timeframes to issue a MNOA or UNOA overlap.

The division invites stakeholder input on the following options and topics for discussion:

- Are there any negative impacts if a MNOA and UNOA are combined in one document, rather than being issued separately? The division does not intend to modify any of the content requirements for these notices, or any of the events that trigger issuing them.
- Should any rule revisions be solely in OAR 436-060, OAR 436-030, or should changes be made in both rule divisions? Please note: Any changes to OAR 436-030 would be logged and deferred until a future rulemaking for that rule division.

Options

1) Amend OAR 436-060-0140 to add the following language:

(Section # to be determined) Combining notices

(a) If an "Initial Notice of Acceptance" is issued at the same time as the "Updated Notice of Acceptance at Closure," both titles must appear near the top of the document.

(b) If a "Modified Notice of Acceptance" is issued at the same time as the "Updated Notice of Acceptance at Closure," both titles must appear near the top of the document.

2) No change.
3) Other.

Fiscal Impacts, including cost of compliance for small business:
No significant impact expected. Under option 1, insurers would still be required to provide the same notice information that is required under current rule; but they could consolidate that information into the same document. Additionally, combining the MNOA and UNOA may only be feasible in some cases, since existing timeframe requirements for issuing these notices would not change. The division does not have data to estimate the fiscal impact, but invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in notices to workers may impact 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.

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Rule: OAR 436-060-0025, Worker's Weekly Wage Calculation and Rate of Temporary Disability Compensation

Issue: The rule does not address how to calculate the worker's weekly wage when the pay rate for overtime earnings fluctuates regularly. In these cases, the existing calculation method set in rule may not be an accurate representation of the worker's weekly wage.

Background:
A worker's temporary disability benefits are based on a calculation of their weekly wage; and when a worker's wages vary, the weekly wage is typically based on their wages in the 52 weeks prior to the date of injury.

OAR 436-060-0025 provides how the weekly wage should be calculated. In some cases, the rule specifies the weekly wage must be calculated using the "average hours" method under OAR 436-060-0025(4)(b)(C). This method is used if there was a pay rate change in the 52 weeks before their injury, and is based on determining the average hours worked per week for each pay rate, and multiplying by the pay rate at injury.

Example A – Weekly wage calculation using average hours method

Pay type	Avg. hours per week	Pay rate on date of injury	Hours x Pay rate
Regular	40	$22	$880
Overtime	12	$33	$396
		Weekly wage	**$880 + $396 = $1,276**

The above example assumes there is one pay rate for overtime, but in some cases, the overtime rate regularly fluctuates. Examples B and C below show how an overtime rate might fluctuate, based on scenarios developed from stakeholder inquiries.

Example B - This worker had an overtime pay rate that fluctuated (even within a given week), and no one single rate was used to pay the worker.

Week	Regular rate	Overtime rate
Week 1	$21	$31.63
Week 2	$21	$31.7
Week 3	$21	$31.5
Week 4	$22	$33.70, $33.57
Week 5	$22	$33
Week 6	$22	$33.7, $33.57
Week 7	$22	$33.48, $33.33
Week 8	$22	$33.57
Week 9 (week of injury)	$22	$33.11

Example C - The rate for overtime pay was based on the number of hours worked in a week. Additionally, the overtime rate was established at the end of the each week. As a result, the overtime rate could not be determined for week or date of the injury, because the worker had not completed a full week of work.

Week	Hours worked	Overtime rate per hour
Week 1	45	$30
Week 2	52	$32
Week 3	57	$34
Week 4	43	$30
Week 5	54	$32
Week 6 (week of injury)	25	Not determined

When the overtime rate fluctuates, the rule language is not clear about how to calculate the weekly wage. OAR 436-060-0025 requires calculating the weekly wage based on the pay rate on the date of injury, but does not address what pay rate to use if the overtime pay rate fluctuates regularly.

A insurer can technically comply with the rule by simply using the overtime pay rate on the date of injury. However, this is only possible if it is clear what the overtime pay rate was on the date of injury. Additionally, even if the overtime pay rate for the date of injury is known, using it may conflict with the intent of the rule. The overall intent of OAR 436-060-0025 is to calculate a weekly wage that approximates the worker's typical wage at the time of injury. Using the overtime pay rate from the date of injury rather than accounting for a rate that fluctuates over time may result in a weekly wage that is higher or lower than normal before the injury.

To be consistent with the intent of the rule, the division is considering revising the rule to clearly outline how fluctuating pay rates should be handled in calculating the weekly wage. The division believes it would be beneficial to revise the rule to address this issue and requests input on the following questions and proposals:

- How often do workers have fluctuating overtime pay rates? Why does the overtime pay rate vary, and how are the rates determined?
- Is it usually overtime rates that vary, or does this occur with other types of pay? (e.g., differential pay for holidays, working on a day off, or weekends)
- If the rule language is revised to account for fluctuating pay rates, should it be specific to overtime, or apply to other fluctuating pay rates?
- Do you have suggestions on how to calculate the weekly wage when a pay rate fluctuates? What calculation would be a reasonable representation of the worker's normal wages?

Proposal 1 – Averaging overtime wages

- Find the total overtime wages for the 52 weeks before the injury.
- Average the total overtime wages over 52 weeks (or less, if the worker was not employed for 52 weeks).

Proposal 2 – Averaging modified overtime wages

- Find the total overtime wages for the 52 weeks before the injury
- Increase the total overtime wages by the percent the worker's regular (not overtime) base pay rate increased during the 52 weeks before the injury
- Average the adjusted overtime wages over 52 weeks (or less, if the worker was not employed for 52 weeks).

Example calculations

Assumptions:

- The worker's weekly wage must be calculated under the average hours method.
- The overtime pay rate fluctuates regularly, but other types of pay do not.
- The worker has a 52 week wage history before the date of injury. The worker's regular base pay increased from $21.35 to $22 per hour on July 1, an increase of three percent. The average hours method must be used due to this pay rate change.
- The worker's regular hours pay has already been calculated using the average hours method, and is $880 per week.

	Proposal 1	Proposal 2
Wages	Overtime wages for the 52 weeks before the date of injury: $7,900	Overtime wages January – June: $3,886 (before the raise) Overtime wages July – December: $4,014 (after the raise) Total: $7,900
Proposed calculation	Average the overtime wages. $7,900 ÷ 52 weeks = $151.92	Increase overtime wages for January – June by 3 percent, add the July – December wages, then average over 52 weeks. (($3,886 x 1.03) + $4,014) ÷ 52 weeks = $154.17
Weekly wage	$880.00 (Regular pay) + $151.92 (Overtime pay) $1,031.92	$880.00 (Regular pay) + $154.17 (Overtime pay) $1,034.17

Options

1) Revise OAR 436-060-0025 to incorporate proposal 1.
2) Revise OAR 436-060-0025 to incorporate proposal 2.
3) Other.
4) No change.

Fiscal Impacts, including cost of compliance for small business:
Insurers, self-insured employers, and service companies may need to adjust their processes to comply with any rule changes. Additionally, revisions to the weekly wage calculation may change the amount of benefits paid to workers. The division does not have data to estimate the

fiscal impact, but invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in workers' compensation benefits may impact 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.

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Rule: OAR 436-060-0025, Worker's Weekly Wage Calculation and Rate of Temporary Disability Compensation

Issue: Sign on and relocation bonuses may be included when calculating the worker's weekly wage. However, including them may not be a reasonable approximation of the worker's weekly wage.

Background:
A worker's weekly wage must be calculated in accordance with OAR 436-060-0025, and is generally based on the worker's wages before the date of injury.

Currently, bonus pay is included in the wages used for the weekly wage calculation as long it fits the definitions of wages in OAR 436-060-0005(19) and ORS 656.005(27). However, prior to 2017, OAR 436-060-0025 limited when bonuses could be included in the worker's weekly wage. Bonuses were only included if they were provided as part of the written or verbal employment contract as a means to increase the worker's wages. End of the year and other one-time bonuses paid at the employer's discretion were not included in the calculation of compensation. These limits were removed in 2017 as a part of a broader effort to simplify the weekly wage calculation.

Although the rule no longer limits when bonuses may be included in the weekly wage calculation, since 2020, the division has noticed an increase in questions regarding sign on and relocation bonuses paid to a worker when they are hired, to incentivize them to accept the job. Prior to the COVID pandemic, the division rarely saw examples where sign on or relocation bonuses were a factor in weekly wage calculations. Since the pandemic, it's become more common and stakeholders have asked whether these bonuses should be included when calculating the worker's weekly wage. In general, the division's stance is that if a sign on or relocation bonus fits the definition of wages, it must be included, since there are no longer limits on including bonuses in rule.

However, since a sign on or relocation bonus might be granted only once and specifically for accepting a job, it may not be a wage that needs to be replaced while the worker loses time from work due to the injury. If the bonus is already fully paid out before the date of injury, the worker will not be losing the bonus wages.

The methods set for calculating the weekly wage in OAR 436-060-0025 are intended to approximate the worker's weekly wage at the time of injury. Given the circumstances sign on and relocation bonuses may be paid under, the division is considering whether the rule should exclude them, to ensure the calculation approximates the weekly wage.

Based on authority established in ORS 656.210, the division may establish methods in OAR 436-060-0025 that approximate the worker's weekly wage. The rule could be revised to reinstate the pre-2017 rule language, which specified when bonuses were excluded from the weekly wage

calculation, and broadly applied to all types of bonuses. Alternatively, the rule could be revised to specifically address excluding one time bonuses (such as sign on or relocation bonuses).

The division invites input on the following options, and feedback on the frequency or nature of sign on or relocation bonuses.

Options

1) Within OAR 436-060-0025 or OAR 436-060-0005(19), limit when one time bonuses (such as sign on or relocation bonuses) may be included in the weekly wage calculation.

   OAR 436-060-0025
   (# Section number to be determined) One time bonus
   A one time bonus (e.g., a sign on or relocation bonus) paid to the worker for accepting a job offer may not be included in the wages used to calculate the worker's weekly wage.

2) Revise OAR 436-060-0025, to include the pre-2017 rule language used to generally limit inclusion of bonuses:

   "Bonus pay shall be considered only when provided as part of the written or verbal employment contract as a means to increase the worker's wages. End-of-the-year and other one time bonuses paid at the employer's discretion shall not be included in the calculation of compensation."

3) No change.

4) Other.

Fiscal Impacts, including cost of compliance for small business:
Insurers, self-insured employers, and service companies may need to adjust their processes to comply with any rule changes. Additionally, limiting when one time bonuses may be included may decrease the amount of benefits paid to workers. The division does not have data to estimate the fiscal impact, but invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, decreases in workers' compensation benefits may impact 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.

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Rule: OAR 436-060-0025, Worker's Weekly Wage Calculation and Rate of Temporary Disability Compensation

Issue: The division identified a specific circumstance where the calculation method in the rule could result in a worker weekly wage of $0.

Background:
Under OAR 436-060-0025, if a worker receives irregular wages, the insurer must calculate the worker's weekly wage based on average wages for the period up to 52 weeks before the date of injury. Often, insurers use a full 52 weeks of wages, or if employed less than 52 weeks, the actual number of weeks of employment. In cases where the worker has been employed less than four weeks, the intent of the wage earning agreement between the worker and employer is used.

The division's audit team recently became aware of a circumstance raised by a stakeholder where the rule does not address how to calculate the worker's weekly wage, and may produce a nonsensical result. The circumstance raised by the stakeholder follows:

- The worker had been employed over a year, but the expectation of their position was that they only worked very sporadically.
- There was no change in the worker's wage earning agreement in the 52 weeks before the injury, and there was no break in employment.
- The worker had earned wages on the date of injury, but didn't have any wages in the 52 weeks prior.

Though the stakeholder later learned that wages had been earned in the 52 week period, the initial question raised a problem, If the insurer strictly followed the current rule to calculate the worker's weekly wage, the calculation would be a weekly wage of $0. However, since the worker earned wages on the date of injury, a weekly wage of $0 would be nonsensical and defeat the purpose of temporary disability benefits.

Though this is a particularly unique and rare circumstance, because of the potential for a highly problematic result, the division is considering revising the rule to require using the intent of the worker's wage earning agreement in this circumstance. The division invites input on this option, or others that would ensure the weekly wage is not $0.

Options
1) Amend OAR 436-060-0025 as follows:

(4) Calculation of irregular wages.
If the worker receives irregular wages, the insurer must calculate the worker's irregular wages to determine the worker's average weekly wage based on the weekly average of the worker's irregular wages for the period up to 52 weeks before the date of injury or verification of disability caused by occupational disease, subject to the following:

[(a) – (b) omitted]

(c) T~~t~~he insurer must base the rate of compensation on the intent of the worker's wage earning agreement in place at the time of injury or verification of disability caused by occupational disease, as confirmed by the employer and worker, if:

(A) ~~If,~~ O~~o~~n the date of injury or verification of disability caused by occupational disease, the worker was employed by the employer at injury for less than four weeks;~~,~~

(B) ~~or t~~The worker's most recent new wage earning agreement had been in place for less than four weeks;~~,~~ or

(C) In the 52 weeks before the date of injury or verification of disability caused by occupational disease the worker did not earn wages, there was no change in the wage earning agreement; and section (6) of this rule does not apply.

~~the insurer must base the rate of compensation on the intent of the worker's wage earning agreement in place at the time of injury or verification of disability caused by occupational disease, as confirmed by the employer and worker~~

2) No change.
3) Other

Fiscal Impacts, including cost of compliance for small business:
No significant impact anticipated; this proposal would address very rare circumstances. However, it would ensure that the worker does not receive zero temporary disability benefits. The division does not have data to estimate the fiscal impact, but invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in workers' compensation benefits may impact 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.

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Rule: OAR 436-060-0030(1)(a), Payment of Temporary Partial Disability Compensation

Issue: The description of post injury wages is inconsistent within the rule.

Background:
OAR 436-060-0030(1)(a) describes how to calculate the temporary partial disability compensation due to a worker.

In (1)(a)(A) of the rule, the first step for this calculation is to "Subtract the worker's post-injury wages from *any kind of work* from the wages at the time of injury under OAR 436-060-0025." (Emphasis added)

In (1)(b) of the rule, the term "post-injury wages" is defined as the sum of:

- The wages the worker could have earned by accepting a job offer, or actual wages earned, whichever is greater;
- *Any unemployment benefits received*; and
- *Any wages received for paid leave*, except wages paid in addition to temporary disability compensation with the worker's consent under OAR436-060-0025(1).

(1)(a)(A) of the rule states to use post-injury wages "from any kind of work," however, the definition in (1)(b) includes unemployment benefits, which are not specifically from work.

The division is considering revising the wording in (1)(a)(A) so it is consistent with the definition in (1)(b).

Options:

1) Revise OAR 436-060-0030(1)(a)(A) as follows:

   Subtract the worker's post-injury wages ~~from any kind of work~~ from the wages at the time of injury under OAR 436-060-0025;

2) No change.
3) Other.

Fiscal impacts, including cost of compliance for small business:
No impact is expected, but the division invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in workers' compensation benefits or processes may impact 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. However, this issue is not expected to change worker benefits or significantly change claim processing.

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Rule: OAR 436-060-0030(1) and (6), Payment of Temporary Partial Disability Compensation

Issue: The instructions for calculating temporary partial disability payments when a modified job no longer exists or when an offer is withdrawn are inconsistent between section (1) and section (6) of the rule.

Background:
Temporary total disability benefits (TTD) are paid when a worker is unable to work on a temporary basis. Temporary partial disability (TPD) benefits are paid when a worker is unable to do their regular work, but can perform modified work. TPD is calculated by reducing the TTD rate based on the worker's earnings from modified work. However, in some cases, the payment for TPD and TTD may be the same, if no modified work is offered or available.

OAR 436-060-0030 describes how to calculate TPD and the circumstances where TPD is paid. OAR 436-060-0030(1) broadly requires that TPD must be calculated by reducing the TTD rate by the wages the worker earns after their injury (the "post-injury wages"). However, OAR 436-060-0030(6) states that if a modified job no longer exists, or the job offer is withdrawn, TPD must be paid at the "full temporary total disability rate."

Under section (6) of the rule, most of the time, the worker is not earning any wages, and should be paid benefits based on the "full temporary total disability rate." However, even if modified work is not available, a worker could receive post-injury wages for paid leave (e.g., vacation or sick leave). Though section (6) states that the full TTD rate must be paid, this is not consistent with section (1) of the rule, which would require reducing by the post-injury wages.

The division believes that rule language in section (6) should be revised to be consistent with section (1), to clarify that even if the calculation is based on the TTD rate, any post-injury wages should reduce the rate. This is consistent with the position the Workers' Compensation Board took in *Patricia L. Hutchinson*, 59 Van Natta 1733 (2007). In that case, the board explained that benefits must start at the full TTD rate when a modified job offer was withdrawn, but that post-injury wages should still be included in the computation of TPD, even if the TTD rate is used.

To clarify how the TPD should be calculated in section (6), the division is considering revising the rule as described in Option 1.

Options:

1) Revise OAR 436-060-0030(6) as follows:

(6) If the modified job no longer exists or offer is withdrawn.
Temporary partial disability must be paid at the ~~full~~ temporary total disability rate as of the date a modified job no longer exists or the job offer is withdrawn by the employer.

(a) This section applies to situations including, but not limited to, termination of temporary employment, layoff, or plant closure.
(b) A worker who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim is subject to this section.
(c) For the purpose of this rule, when a worker who has been doing modified work quits the job, or the employer terminates the worker for violation of work rules or other disciplinary reasons, it is not a withdrawal of a job offer by the employer, but must be considered the same as the worker refusing wage earning employment under ORS 656.325(5)(a).
(d) This section does not apply to those situations described in sections (3), (4), and (5) of this rule.
(e) Temporary disability paid under this section must be calculated under section (1) of this rule, accounting for any post-injury wages.

2) No change.
3) Other.

Fiscal Impacts, including cost of compliance for small business:
No impact is expected, but the division invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in workers' compensation benefits or processes may impact 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. However, this issue is not expected to change worker benefits or significantly change claim processing.

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Rule: OAR 436-060-0075 Payment of Death Benefits
OAR 436-075-0030 Permanent Total Disability Benefit

Issue: If the worker has no surviving beneficiaries, it is unclear whether permanent total disability (PTD) benefits should be paid *through* or *to* the date the worker dies. Additionally, it is unclear whether OAR 436-060-0075 or OAR 436-075-0030 should be applied when PTD benefits end due to the worker's death.

Background:
When a worker is eligible for permanent total disability (PTD) benefits, they may receive those benefits until the end of their life. If the worker dies during a period of PTD, under OAR 436-060-0075(7)(b)(A), the insurer must pay death benefits to surviving beneficiaries. Those PTD benefits must be paid *through* the date of death, and death benefits for surviving beneficiaries begin accruing the following day.

OAR 436-060-0075(7)(b)(A) does not address when PTD ends if there are no surviving beneficiaries. Separately, OAR 436-075-0030(3) states that PTD benefits for beneficiaries (which can include the worker) must be paid *to* the date of any status change (which could include the date the worker died). However, OAR 436-075-0030 is not intended to address how to pay PTD benefits when a worker dies.

The division has identified two issues with these rules:

- It is unclear whether PTD should be paid *through* or *to* the date the worker died when there are no surviving beneficiaries
- It is unclear when OAR 436-060-0075 applies, versus OAR 436-075-0030.

Prior to 2018, OAR 436-075 specified that PTD benefits should be paid *to* the date of death if there were surviving beneficiaries, and *through* the date of death when there were no beneficiaries. The current rule originates from a 2018 rule revision. At that time, OAR 436-060 and 436-075 were revised to move some provisions to OAR 436-060, and simplify the end date of PTD. The intent of the revision was to simplify to one standard: paying PTD through the date of death.

To be consistent with the intent of the 2018 rule revision and clarify how benefits should be paid, the division is considering revising OAR 436-060-0075 and 436-075-0030.

Options

1) Revise OAR 436-060-0075(7)(b) to clarify that the benefit is paid through the date of death (regardless of whether they have surviving beneficiaries).

(7) Death during permanent total disability.
If a worker dies during a period of permanent total disability:

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

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

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

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

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

(b) Notwithstanding OAR 436-075-0030(3), permanent total disability benefits must be paid through the date of death. Benefits payable for a partial month must be calculated by dividing the monthly benefit by the actual number of days in the month and multiplying that result by the number of days payable;

(c) The insurer must pay death benefits to surviving beneficiaries in the same manner and same amounts as provided in sections (2) through (6) of this rule.~~:~~

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

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

(d~~e~~) Upon receipt of verifiable documentation or the expiration of the 60-day period in paragraph (5)(b)(B) of this rule, the insurer must:

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

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

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

2) Revise OAR 436-075-0030(2) as follows.

436-075-0030 Permanent Total Disability Benefit

[sections (1) – (2) and (4)-(5) omitted]

(3) Unless otherwise specified in OAR 436-060-0075(7), ~~B~~benefits for beneficiaries must be paid to the date of any status change.

3) No change
4) Other

Fiscal impacts, including cost of compliance for small business:

No impact is expected, but the division invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in workers' compensation benefits or processes may impact 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. However, this issue is not expected to change worker benefits or significantly change claim processing.

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Rule: OAR 436-060-0155, Penalty to Worker for Untimely Processing

Issue: When a penalty is agreed upon by the parties in a stipulation agreement, the penalty is due before the agreement appeal period expires. The rule language appears to limit the appeal period to 14 days, when 30 days is provided under OAR 436-060-0008(4).

Background:
OAR 436-060-0155 allows parties to resolve disputes regarding unreasonable delay or unreasonable refusal to pay compensation through a stipulation agreement. These stipulations must be submitted to the division, and the division may approve the stipulation in an order.

If the stipulation includes an agreement to pay a penalty, under OAR 436-060-0155(6)(c), the penalty payment is due within 14 days after the date the director approves the stipulation, unless otherwise stated in the stipulation.

Under OAR 436-060-0008(4), if a party wants to appeal the director's order approving a stipulation, they have 30 days from the mailing date of the director's order to request a hearing. It is rare for the division to receive an appeal of the stipulation order, likely because it is voluntary and drafted by the parties. However, OAR 436-060-0155 appears to inadvertently limit the appeal period to 14 days, because payment is required before the 30 day appeal period expires.

To ensure the appeal period is not limited to 14 days, and clarify when a penalty should be paid if the stipulation is appealed, the division is considering revising the penalty due date in OAR 436-060-0155(6) to match the appeal period. The division invites input on this issue, along with any other suggestions that would clarify the appeal and payment timeframes.

Options:

1) Revise the penalty due date in OAR 436-060-0155 to 30 days from the date of the stipulation order, and extend the due date if the stipulation order is appealed.

(6) Dispute resolution.
Disputes regarding unreasonable delay or unreasonable refusal to pay compensation, attorney fees or costs, or unreasonable delay in acceptance or denial of a claim may be resolved by the parties.

(a) In cases where the director has exclusive jurisdiction under section (4) of this rule, and the violations occurred within the last 180 days as described in subsection (2)(c) of this rule, then the parties must submit a stipulation to the division for approval. The stipulation must specify:

(A) The benefits, attorney fees, or costs delayed and the amounts;
(B) The time periods involved;
(C) If applicable, the name of the medical providers and the dates of services relating to medical bills;

(D) The amount of the penalty not to exceed 25 percent of the amounts then due under ORS 656.262(11)(a); and
(E) The attorney fees, if applicable.

(b) Any other agreements between the parties to pay a penalty or attorney fee must have a stipulation approved by the director to be acknowledged as a violation as it applies to the matrix in Appendix "B" of these rules.

(c) Payment of a penalty due under this section is due within 30~~14~~ days after the date the director approves the stipulation, unless the stipulation order is appealed within 30 days of the mailing date of the order~~,~~ or otherwise stated in the stipulation. If the order is appealed and later upheld, the penalty will be due within 14 days of the date of the order upholding the penalty becomes final. If the insurer does not pay penalties in a timely manner the insurer will be subject to civil penalties under OAR 436-060-0200.

2) No change.
3) Other

Fiscal Impacts, including cost of compliance for small business:
No significant impact anticipated; this proposal would address a rare circumstance. The division does not have data to estimate the fiscal impact, but invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in workers' compensation benefits may impact 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. However, this issue is not expected to change worker benefits or significantly change claim processing.

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Rule: OAR 436-060-0200, Assessment of Civil Penalties

Issue: Certain sections of this rule appear to be redundant or outdated.

Background:
OAR 436-060-0200 details circumstances where the director may assess a civil penalty against an employer or insurer. However, the division has noted that several sections of the rule are already covered by section (2) of the rule, or are outdated, and is considering streamlining the rule.

Section 2: Penalties for failure to comply with statutes, rules, and orders
Section (2) establishes that the director may assess penalties for violations of Oregon Revised Statutes (ORS) chapter 656 and Oregon Administrative Rules (OAR) chapter 436. Section (2) states:

- "The director may assess a civil penalty under ORS 656.745(2) against an employer or insurer that violates ORS chapter 656, OAR chapter 436, or orders of the director regarding reports or other requirements necessary to carry out the purposes of ORS chapter 656."
- "Except as provided in ORS 656.780, the director may assess a civil penalty against a service company only for claims processing violations identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an employer, insurer, or service company identified in an annual audit."

Sections 3 - 6: Penalties for failure to meet time frame requirements, use of sight draft to pay compensation, inaccurate reporting of first payment timeliness, and failure to comply with claims processing requirements
Sections (3) – (6) state that penalties can be assessed for specific circumstances or rules within ORS chapter 656 or OAR chapter 436. However, they appear redundant, because section (2) broadly provides that the division may assess penalties for refer to requirements listed in OAR Chapter 436 and ORS Chapter 656. These sections also describe a penalty against service companies that is already mentioned in Section (2).

Section 8: Performance audits
Section (8) indicates "acceptable standards" for performance audits are stated in rule and orders of the director, but that does not reflect the current audit process. Currently, in practice, audit standards are generally stated in industry notices, and in written communications to the insurer when an audit is scheduled. Previously, this section of the rule specifically addressed acceptable standards and penalties for the Quarterly Claims Processing Performance audit (QCPP). However, the division no longer issues any quarterly penalties related to QCPP, and standards related to QCPP were removed from rule.

Section 9: Considerations for assessing penalties
Section (9) lists factors the director may consider in determining the amount of a penalty. In determining amounts of civil penalties, the division's audit team only applies the first factor for one area of auditing, and does not apply the other two factors. Additionally, because the rule does not require considering these factors, this section may be unnecessary.

Options
1) Revise OAR 436-060-0200 as follows.

a. Remove sections (3), (4), (5), and (6) and maintain the general civil penalty authority under section 2.

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

c. Remove section (9).

2) No changes.

3) Other.

Fiscal Impacts, including cost of compliance for small business:
No impact anticipated. The changes align the rule with current practices without altering them. The division does not have data to estimate the fiscal impact, but invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in the workers' compensation system may impact 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. However, this issue is not expected to change worker benefits or significantly change claim processing.

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

Issue: The rule is unclear regarding the types of settlements that must be submitted to the division for approval.

Background:
If an insurer elects to pay supplemental temporary disability benefits to a worker, the division will reimburse the insurer for the amount they paid. These reimbursements are made from the Workers' Benefit Fund.

In some cases, the parties involved in a claim will agree on settling the claim with an agreement that includes amounts for supplemental disability benefits. In those cases, OAR 436-060-0500 requires the insurer to submit the settlement or disposition agreement to the division for approval, before it is ultimately approved by the Workers' Compensation Board. If not submitted to the division, the insurer is not eligible to receive reimbursement for the amount of the supplemental temporary disability benefits.

The current rule specifies that "claim disposition agreements or stipulated claims settlements, under ORS 656.236 or 656.289" must be submitted to the division. This wording and the specific references to statute clearly includes a claim disposition agreements (CDA) and disputed claim settlement (DCS), but does not clearly include a third type of agreement that may be used: a stipulation agreement. To be consistent with treatment of CDA and DCSs, the division is considering clarifying in rule that stipulation agreements should also be submitted to the division for review.

Options

1) Amend OAR 436-060-0500(6) as follows.

(6) Claim disposition agreements, disputed claim settlements, and settlement stipulationsed claims settlements.
Claim dispositions agreements under ORS 656.236, disputed claim settlements under ORS 656.289, or other settlement stipulationsed settlements regarding matters under ORS chapter 656, under ORS 656.236 or 656.289, that include amounts for supplemental disability benefits due to multiple jobs, are not eligible to receive reimbursement from the Workers' Benefit Fund unless they receive written confirmation from the director before the disposition, or settlement, or stipulation is approved by the Worker's' Compensation Board.

(a) To receive written confirmation of a proposed disposition, or settlement, or stipulation, the insurer must submit a request to the division. The request for written confirmation must include:

(A) A copy of the proposed disposition, or settlement, or stipulation that specifies the exact amount of the proposed contribution to be made from the Workers' Benefit Fund;

(B) A statement from the insurer indicating how the amount of the contribution was calculated; and
(C) Any other information required by the director.

(b) The director will not confirm the disposition, settlement, or stipulation for reimbursement if the proposed contribution exceeds a reasonable projection of that claim's future liability to the Workers' Benefit Fund.

2) No change.
3) Other.

Fiscal Impacts, including cost of compliance for small business:
No impact anticipated. The division does not have data to estimate the fiscal impact, but invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in workers' compensation benefits may impact 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. However, this issue is not expected to change worker benefits or significantly change claim processing.

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Issue: Information that affects a worker's eligibility for a worker requested medical exam (WRME) is frequently submitted after the division has found the worker eligible for a WRME. Late submissions can result in the worker's eligibility being retroactively rescinded, and make the WRME process more complex.

Rule: OAR 436-060-0147 Worker Requested Medical Examination

Background:
In some cases, when a worker's claim is denied, the worker may obtain a worker requested medical exam (WRME). WRMEs provide additional medical evidence regarding the worker's injury and medical condition, and the worker may use this evidence to build their case when appealing the denial. Workers are eligible for a WRME if the following criteria are met:

- The worker has made a timely request for a board hearing on a denial of compensability;
- The denial is based on one or more independent medical examination reports; and
- The attending physician or authorized nurse practitioner does not concur with the report or reports.

To obtain a WRME, the worker must submit a request to the division, and simultaneously copy the insurer. After reviewing the request, the division will issue an order regarding the worker's eligibility. If the worker is found eligible, they may schedule and attend the WRME. However, during this process, insurers sometimes submit information to the division to object to the worker's request. For example, if the insurer has documentation that the attending physician *did* concur with the independent medical exam (which would make the worker ineligible), they could submit an objection for the division to consider.

Since 2020, the number of WRME requests submitted to the division has doubled, and as a result, more objections are being submitted. Additionally, the division frequently receives objections after the eligibility order has been issued. When objections are submitted late, if the 60 day appeal period for the eligibility order has not expired, the division considers the new information, and may rescind the worker's eligibility.

However, in cases where eligibility is rescinded, because the worker was initially informed they were eligible, the worker may have already scheduled or attended a WRME. It is confusing for the worker when their eligibility is rescinded, and it can affect how they proceed in appealing the denial of compensability. Additionally, though the modified eligibility decision may be more accurate, the late submission and subsequent rescission can be an inequitable and inefficient process. To address these issues, the division is considering revising OAR 436-060-0147 to specify a timeframe for submitting information that affects eligibility. The division requests input on the issue, the following questions, and options.

- How often do insurers submit objections to a WRME?
- Are there factors that delay submitting objections?
- Do late objections have any other impacts not noted above?
- How could the WRME process be modified to address this issue?

Options

1) Revised OAR 436-060-0147 to require the insurer to submit any objection to the division within 14 days of the worker's request for a WRME, or within 30 days of the worker's request for a board hearing, whichever is later.

(3) Required documentation.

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

(A~~a~~) Acted as the worker's attending physician or authorized nurse practitioner;

(B~~b~~) Provided medical consultations or treatment to the worker;

(C~~c~~) Examined the worker at an independent medical examination requested by the insurer under ORS 656.325; or

(D~~d~~) Reviewed the worker's medical records on the claim.

(b) If the insurer disagrees with the worker's request for a worker requested medical examination, the insurer must submit an explanation and any supporting documentation to the division within 14 days of the insurer's receipt of the worker's request, or within 30 days of the date the worker requested a hearing under subsection (1)(a) of this rule, whichever is later.

2) No change.

3) Other.

Fiscal Impacts, including cost of compliance for small business:
The division does not have data to estimate the fiscal impact, but invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule affect racial equity in this state:
The 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 Americans 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, changes in the workers' compensation system may impact 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.

Housekeeping

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OAR 436-060-0030(3)
Correcting grammar by replacing “and” with “if” as follows:

> Except when the worker refuses modified work under ORS 656.268(4)(c), the insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation as if the worker had begun the employment from the date a worker fails to begin regular or modified employment, if~~and~~ the following conditions have been met:

OAR 436-060-0140(6)(b)
Amending the wording and grammar of subsection (b) regarding when a modified notice of acceptance must be issued, for clarity.

> (b) An insurer must issue a "Modified Notice of Acceptance" (MNOA) when the insurer:
> (A) Accepts a new or omitted condition ~~on a nondisabling claim, while a disabling claim is open or after claim closure~~;
> (B) Accepts an aggravation claim;
> (C) Changes the disabling status of the claim; or
> (D) Amends a notice of acceptance, including correcting a clerical error, except for an error or omission on an "Updated Notice of Acceptance at Closure."

OAR 436-060-0018(3)(b)(B)(i) and (ii)
OAR 436-060-0018(6)(a)(C)(i) and (ii)
OAR 436-060-0020(5)(b)(A) and (B)
OAR 436-060-0020(5)(d)(A) and (B)
OAR 436-060-0030(3)(c)(G)(i) and (ii)
OAR 436-060-0095(3)(e)(I)(i) and (ii)
OAR 436-060-0095(6)(j)(A) and (B)
OAR 436-060-0105(2)(d)(A) and (B)
OAR 436-060-0105(4)(b)(G)(i) and (ii)
OAR 436-060-0105(5)(a)(D)(i) and (ii)
OAR 436-060-0135(2)(a)(A)(iv)(I) and (II)
OAR 436-060-0137(3)(a)(G)(i) and (ii)
OAR 436-060-0137(5)(b)(I)(i) and (ii)
Removing mandatory notice language to workers that became obsolete as of Oct. 1, 2024, and renumbering the rules accordingly. New notice language that went into effect starting Oct. 1, 2024 will remain.

OAR 436-060-0018, 436-060-0035, 436-060-0137
Updating instances where “appeal” is used when the rule describes the exact action required to appeal, if the appeal goes to the Workers’ Compensation Division or Workers’ Compensation Board. The term “appeal” technically only refers to requests that go to a court (such as the Oregon Court of Appeals or Oregon Supreme Court). These updates would revise the rule to describe the required action more accurately (e.g., from “submit an appeal” to “request review by the board”).

OAR 436-060-0018(3)(c) and (7)(c)

(3) Worker request for reclassification.

A worker may request the insurer review the classification of a nondisabling claim under ORS 656.277 if the claim has been classified as nondisabling for one year or less after the date of acceptance and the worker believes the claim was or has become disabling.

(c) If the worker disagrees with the insurer's decision in the Notice of Refusal to Reclassify, the worker may submit a request for review~~appeal~~ to the director under section (7) of this rule:

(A) The request for review ~~appeal~~ must be made no later than the 60th day after the mailing date of the Notice of Refusal to Reclassify; and

(B) A copy of the insurer's Notice of Refusal to Reclassify must be provided to the director

(7) Appeal of insurer's classification decision.

If a worker disagrees with an insurer's decision to not reclassify the worker's claim from nondisabling to disabling, the worker may appeal the decision by requesting review by the director:

(c) The worker does not need to be represented by an attorney to request review of ~~appeal~~ the insurer's reclassification decision under section (3) or (6) of this rule. If a worker appeals an insurer's reclassification decision:

(A) The worker's request for review~~appeal~~ must be copied to the insurer;

(B) The director will acknowledge receipt of the request for review~~appeal~~ in writing to the worker, the worker's attorney, if any, and the insurer, and initiate the review;

(C) Within 14 days of the director's acknowledgement:

(i) The insurer must provide the director and all other parties with the complete medical record and all official actions and notices on the claim. The director may impose penalties against an insurer under OAR 436-060-0200 if the insurer fails to provide claim documents in a timely manner; and

(ii) The worker may submit any additional evidence for the director to consider. Copies must be provided to all other parties at the same time; and

(D) After receipt and review of the required documents, the director will issue an order:

(i) The worker and the insurer have 30 days from the mailing date of the director's order to request a hearing~~appeal the director's decision to~~ by the board; and

(ii) The director may reconsider, abate, or withdraw any order before the order becomes final by operation of law.

OAR 436-060-0035(8)(b) and (10)

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

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

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

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

(a) If the worker requests a hearing on the insurer's decision concerning the worker's eligibility for supplemental disability, the worker must submit ~~an~~ the request for hearing~~appeal~~ of the insurer's or the assigned processing administrator's decision within 60 days of the notice in section (5) of this rule.
(b) The insurer for the primary job is not required to contact the secondary job employer. The worker is responsible to provide any necessary documentation.

OAR 436-060-0137(2)(c)

(2) Allowed number of vocational evaluations. The insurer may request no more than three separate vocational evaluations without authorization from the director. Insurers that fail to obtain authorization from the director for additional vocational evaluations may be assessed a civil penalty.

[(a) and (b) omitted for brevity]

(c) The director's decision approving or denying more than three vocational evaluations may be appealed by requesting a hearing by~~to~~ the board within 60 days of the order.