WCD 2-2017(Temp)

Secretary of State
Certificate and Order for Filing

TEMPORARY ADMINISTRATIVE RULES

A Statement of Need and Justification accompanies this form.

FILED
4-10-17 1:25 PM
ARCHIVES DIVISION
SECRETARY OF STATE

I certify that the attached copies are true, full and correct copies of the TEMPORARY Rule(s) adopted on Upon filing. by the

Department of Consumer and Business Services, Workers' Compensation Division	436
Agency and Division	Administrative Rules Chapter Number
Fred Bruyns	(503) 947-7717
Rules Coordinator	Telephone
PO Box 14480, Salem, OR 97309-0405	
Address	

To become effective 04/11/2017 through 10/07/2017.

RULE CAPTION

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

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

RULEMAKING ACTION

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

ADOPT:

AMEND:
436-010-0001, 436-010-0280, 436-030-0003, 436-030-0020, 436-030-0035, 436-035-0003, 436-035-0006, 436-035-0013

SUSPEND:

Statutory Authority:
ORS 656.268, 656.726(4)

Other Authority:

Statutes Implemented:
ORS 656.214, 656.252, 656.268

RULE SUMMARY

These temporary rules:
- Reflect changes in interpretation of workers' compensation statutes by the Oregon Supreme Court in Brown v. SAIF Corporation, 361 Or 241 (2017), primarily the court's determination that "otherwise compensable injury" in ORS 656.005(7)(a)(B), refers to a medical condition and not to an injury incident;
- Eliminate references to a "condition directly resulting from the work injury"; and
- Replace some uses of the term "compensable injury" with "accepted condition."

Fred Bruyns	fred.h.bruyns@oregon.gov
Rules Coordinator Name	Email Address

Secretary of State

STATEMENT OF NEED AND JUSTIFICATION

A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

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

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

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

In the Matter of:

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

Statutory Authority:
ORS 656.268, 656.726(4)

Other Authority:

Statutes Implemented:
ORS 656.214, 656.252, 656.268

Need for the Temporary Rule(s):
Temporary rules are needed to bring OAR chapter 436 into alignment with ORS chapter 656 as interpreted by the Oregon Supreme Court in Brown v. SAIF Corporation, 361 Or 241 (2017). The Court's interpretation affects the rules governing claim closure by insurers and self-insured employers, as well as reconsideration of claim closures by the Workers' Compensation Division. These rules will provide needed guidance for parties and explain how the division will carry out its responsibilities.

Documents Relied Upon, and where they are available:
The Supreme Court's opinion in Brown v. SAIF Corporation, 361 Or 241 (2017), is available on the Oregon Judicial Department's website at: http://www.publications.ojd.state.or.us/docs/S062420.pdf. This document is also available for public inspection upon request to the Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879. Please contact Fred Bruyns, rules coordinator, 503-947-7717, fred.h.bruyns@oregon.gov.

Justification of Temporary Rule(s):
Failure to act promptly will result in serious prejudice to the public interest or the interest of the parties concerned. The Supreme Court's decision affects the Workers' Compensation Division's interpretation of the meaning of "compensable condition" as used in ORS chapter 656.

The agency finds that issuing temporary rules under ORS 183.335(5) is appropriate. Swift action is warranted so insurers, self-insured employers, providers, attorneys, and the division do not operate under rules that are inconsistent with practice.

The agency finds that issuing permanent rules under ORS 183.335(2) and (3) is not appropriate because during the time required to promulgate permanent rules, in the absence of temporary rules to fill the gap, insurers, self-insured employers, and the division would have to ignore some provisions in the administrative rules. This could lead to errors in claim closure and reconsideration, and a consequent increase in litigation.

Fred Bruyns — Printed Name
fred.h.bruyns@oregon.gov — Email Address

Authorization Page

Generated on April 10, 2017 8:38AM

TEMPORARY ADMINISTRATIVE RULES

Department of Consumer and Business Services, Workers' Compensation Division	436
Agency and Division	Administrative Rules Chapter Number
Fred Bruyns	fred.h.bruyns@oregon.gov
Rules Coordinator	Email Address
PO Box 14480, Salem, OR 97309-0405	503-947-7717
Address	Telephone

Upon filing.

Adopted on

04/11/2017 thru 10/07/2017

Effective dates

RULE CAPTION

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

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND:

436-010-0001,436-010-0280,436-030-0003,436-030-0020,436-030-0035,436-035-0003,436-035-0006,436-035-0013

SUSPEND:

Stat. Auth.: ORS 656.268, 656.726(4)

Other Auth.:

Stats. Implemented: ORS 656.214, 656.252, 656.268

RULE SUMMARY

These temporary rules:

- Reflect changes in interpretation of workers' compensation statutes by the Oregon Supreme Court in Brown v. SAIF Corporation, 361 Or 241 (2017), primarily the court's determination that 'otherwise compensable injury' in ORS 656.005(7)(a)(B), refers to a medical condition and not to an injury incident;
- Eliminate references to a 'condition directly resulting from the work injury';

and
- Replace some uses of the term 'compensable injury' with 'accepted condition.'

STATEMENT OF NEED AND JUSTIFICATION

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

In the Matter of

The Supreme Court's opinion in Brown v. SAIF Corporation, 361 Or 241 (2017), is available on the Oregon Judicial Department's website at: http://www.publications.ojd.state.or.us/docs/S062420.pdf. This document is also available for public inspection upon request to the Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879. Please contact Fred Bruyns, rules coordinator, 503-947-7717, fred.h.bruyns@oregon.gov.

Documents Relied Upon, and where they are available

Temporary rules are needed to bring OAR chapter 436 into alignment with ORS chapter 656 as interpreted by the Oregon Supreme Court in Brown v. SAIF Corporation, 361 Or 241 (2017). The Court's interpretation affects the rules governing claim closure by insurers and self-insured employers, as well as reconsideration of claim closures by the Workers' Compensation Division. These rules will provide needed guidance for parties and explain how the division will carry out its responsibilities.

Need for the Temporary Rule(s)

Failure to act promptly will result in serious prejudice to the public interest or the interest of the parties concerned. The Supreme Court's decision affects the Workers' Compensation Division's interpretation of the meaning of "compensable condition" as used in ORS chapter 656.

The agency finds that issuing temporary rules under ORS 183.335(5) is appropriate. Swift action is warranted so insurers, self-insured employers, providers, attorneys, and the division do not operate under rules that are inconsistent with practice.

The agency finds that issuing permanent rules under ORS 183.335(2) and (3) is not appropriate because during the time required to promulgate permanent rules, in the absence of temporary rules to fill the gap, insurers, self-insured employers, and the division would have to ignore some provisions in the administrative rules. This could lead to errors in claim closure and reconsideration, and a consequent increase in litigation.

Justification of Temporary Rules

Authorized Signer	Louis Savage	April 10, 2017
	Printed Name	Date

Authorization Page replaces the ink signature on paper filings. Have your authorized signer sign and date, then scan and attach it to your filing. You must complete this step before submitting your Permanent and Temporary filings.

436-010-0001
Administration of These Rules
(1) Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.
(2) Authority for Rules. These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) for administration of and pursuant to ORS chapter 656, particularly: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794.
(3) Purpose.
The purpose of these rules is to establish uniform guidelines for administering the delivery of and payment for medical services to workers within the workers' compensation system.
(4) Applicability of Rules.
(a) These rules apply on or after the effective date to carry out the provisions of ORS 656.245, 656.247, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794, and govern all providers of medical services licensed or authorized to provide a product or service under ORS chapter 656.
(b) The changes to OAR 436-010-0280(8) adopted effective April 11, 2017, apply to all closing exams performed on or after April 11, 2017.
(c) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.
Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, 656.794

436-010-0280
Determination of Impairment / Closing Exams
(1) When a worker has received compensation for time loss or it is likely the worker has permanent impairment and becomes medically stationary, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. If the worker is under the care of an authorized nurse practitioner or a type B attending physician, other than a chiropractic physician, the provider must refer the worker to a type A attending physician to do a closing exam.
(2) The closing exam must be completed under OAR 436-030 and 436-035 and Bulletin 239. (See Appendix A "Matrix for Health Care Provider Types".)
(3) When the attending physician completes the closing exam, the attending physician has 14 days from the medically stationary date to send the closing report to the insurer. When the attending physician does not complete the closing exam, the attending physician must arrange, or ask the insurer to arrange, a closing exam with a consulting physician within seven days of the medically stationary date.
(4) When an attending physician or authorized nurse practitioner requests a consulting physician to do the closing exam, the consulting physician has seven days from the date of the exam to send the report to the attending physician for concurrence or objections. Within seven days of receiving the closing exam report, the attending physician must state in writing whether the physician concurs with or objects to all or part of the findings of the exam, and send the concurrence or objections with the report to the insurer.
(5) The attending physician must specify the worker's residual functional capacity if:
(a) The attending physician has not released the worker to the job held at the time of injury because of a permanent work restriction caused by the compensable injury, and
(b) The worker has not returned to the job held at the time of injury, because of a permanent work restriction caused by the compensable injury.
(6) Instead of specifying the worker's residual functional capacity under section (5) of this rule, the attending physician may refer the worker for:
(a) A second-level physical capacities evaluation (see OAR 436-009-0060) when the worker has not been released to return to the job held at the time of injury, has not returned to the job held at the time of injury, has returned to modified work, or has refused an offer of modified work; or
(b) A work capacities evaluation (see OAR 436-009-0060) when there is a question of the worker's ability to return to suitable and gainful employment. The provider may also be required to specify the worker's ability to perform specific job tasks.
(7) When the insurer issues a major contributing cause denial on an accepted claim and the worker is not medically stationary:
(a) The attending physician must do a closing exam or refer the worker to a consulting physician for all or part of the closing exam; or
(b) An authorized nurse practitioner or a type B attending physician, other than a chiropractic physician, must refer the worker to a type A attending physician for a closing exam.
(8) The closing report must include all of the following:
(a) Findings of permanent impairment.
(A) In an initial injury claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted condition or a direct medical sequela of an accepted condition.
(B) In a new or omitted condition claim, the closing report must include objective findings of any permanent impairment that is caused

in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.
(C) In an aggravation claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.
(D) In an occupational disease claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.
(b) Findings documenting permanent work restrictions.
(A) If the worker has no permanent work restriction, the closing report must include a statement indicating that:
(i) The worker has no permanent work restriction; or
(ii) The worker is released, without restriction, to the job held at the time of injury.
(B) In an initial injury claim, the closing report must include objective findings documenting any permanent work restriction that:
(i) Prevents the worker from returning to the job held at the time of injury; and
(ii) Is caused in any part by an accepted condition or a direct medical sequela of an accepted condition.
(C) In a new or omitted condition claim, the closing report must include objective findings documenting any permanent work restriction that:
(i) Prevents the worker from returning to the job held at the time of injury; and
(ii) Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.
(D) In an aggravation claim, the closing report must include objective findings documenting any permanent work restriction that:
(i) Prevents the worker from returning to the job held at the time of injury; and
(ii) Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.
(E) In an occupational disease claim, the closing report must include objective findings documenting any permanent work restriction that:
(i) Prevents the worker from returning to the job held at the time of injury; and
(ii) Is caused in any part by an accepted occupational disease or a direct medical sequel of an accepted occupational disease.
(c) A statement regarding the validity of an impairment finding is required in the following circumstances:
(A) If the examining physician determines that a finding of impairment is invalid, the closing report must include a statement that identifies the basis for the determination that the finding is invalid.
(B) If the examining physician determines that a finding of impairment is valid but the finding is not addressed by any applicable validity criteria under Bulletin 239, the closing report must include a statement that identifies the basis for the determination that the finding is valid.
(C) If the examining physician chooses to disregard applicable validity criteria under Bulletin 239 because the criteria are medically inappropriate for the worker, the closing report must include a statement that describes why the criteria would be inappropriate.
Stat. Auth: ORS 656.726(4), 656.245(2)(b)
Stats. Implemented: ORS 656.245, 656.252

436-030-0003
Applicability of Rules
(1) Except as provided in section (3) of this rule, these rules apply to all accepted claims for workers' compensation benefits and all claims closed on or after the effective date of these rules.
(2) All orders the division issues to carry out the statute and these rules are considered an order of the director.
(3) These rules carry out ORS 656.005, 656.214, 656.262, 656.268, 656.273, 656.278, and 656.325.
(a) 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.
(b) 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.
(c) The changes to OAR 436-030-0020 and 436-030-0035 adopted effective April 11, 2107, apply to:
(A) All notices of closure issued on or after April 11, 2017; and
(B) All requests for reconsideration pending before the Appellate Review Unit as of April 11, 2017.
Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.005, 656.206, 656.210, 656.212, 656.214, 656.262, 656.268, 656.273, 656.278, 656.325, 656.726

436-030-0020
Requirements for Claim Closure
(1) **Issuance of a Notice of Closure.** Unless the worker is enrolled and actively engaged in training, the insurer must issue a Notice of Closure on an accepted disabling claim within 14 days when:
(a) Medical information establishes that there is sufficient information to determine the extent of permanent disability and indicates that the worker is medically stationary;
(b) The compensable injury is no longer the major contributing cause of the worker's combined or consequential condition(s), a major contributing cause denial has been issued, and there is sufficient information to determine the extent of permanent disability;
(c) The worker fails to seek medical treatment for 30 days for reasons within the worker's control and the worker has been notified of pending actions in accordance with these rules;
(d) The worker fails to attend a mandatory closing examination for reasons within the worker's control and the worker has been notified of pending actions in accordance with these rules; or

(e) A worker receiving permanent total disability benefits has materially improved and is capable of regularly performing work at a gainful and suitable occupation.
(2) **Sufficient Information.** For purposes of determining the extent of permanent disability, except as provided in section (14) of this rule for closure after training, "sufficient information" requires: a qualifying statement of no permanent disability under subsection (a) of this section or a qualifying closing report under subsection (b) of this section. Additional documentation is required under subsection (c) of this section unless there is clear and convincing evidence that an attending physician or authorized nurse practitioner has released the worker to the job held at the time of injury or that the worker has returned to the job held at the time of injury.
(a) **Qualifying statements of no permanent disability.** A statement indicating that there is no permanent disability is sufficient if it meets all of the following requirements:
(A) **Qualified providers.** An authorized nurse practitioner or attending physician must provide or concur with the statement.
(B) **Support by the medical record.** The statement must be supported by the medical record. If the medical record reveals otherwise, a closing examination and report specified under subsection (b) of this section are required.
(C) **In initial injury claims.** In an initial injury claim, the statement must clearly indicate the following:
(i) There is no reasonable expectation of any permanent impairment caused in any part by an accepted condition or a direct medical sequela of an accepted condition; and
(ii) There is no reasonable expectation of any permanent work restriction that:
(I) Prevents the worker from returning to the job held at the time of injury; and
(II) Is caused in any part by an accepted condition or a direct medical sequela of an accepted condition.
(D) **In new or omitted condition claims.** In a new or omitted condition claim, the statement must clearly indicate the following:
(i) There is no reasonable expectation of any permanent impairment caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition; and
(ii) There is no reasonable expectation of any permanent work restriction that:
(I) Prevents the worker from returning to the job held at the time of injury; and
(II) Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.
(E) **In aggravation claims.** In an aggravation claim, the statement must clearly indicate the following:
(i) There is no reasonable expectation of any permanent impairment caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition; and
(ii) There is no reasonable expectation of any permanent work restriction that:
(I) Prevents the worker from returning to the job held at the time of injury; and
(II) Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.
(F) **In occupational disease claims.** In an occupational disease claim, the statement must clearly indicate the following:
(i) There is no reasonable expectation of any permanent impairment caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease; and
(ii) There is no reasonable expectation of any permanent work restriction that:
(I) Prevents the worker from returning to the job held at the time of injury; and
(II) Is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.
(b) **Qualifying closing reports.** A closing medical examination and report are required if there is a reasonable expectation of permanent disability. A closing report is sufficient if it meets all of the following requirements:
(A) **Qualified providers.** A type A attending physician or a chiropractic physician serving as the attending physician must provide or concur with the closing report.
(B) **Release to regular work.** If the worker has no permanent work restriction, the closing report must include a statement indicating that:
(i) The worker has no permanent work restriction; or
(ii) The worker is released, without restriction, to the job held at the time of injury.
(C) **In initial injury claims.** In an initial injury claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:
(i) Any permanent impairment caused in any part by an accepted condition or a direct medical sequela of an accepted condition; and
(ii) Any permanent work restriction that:
(I) Prevents the worker from returning to the job held at the time of injury; and
(II) Is caused in any part by an accepted condition or a direct medical sequela of an accepted condition.
(D) **In new or omitted condition claims.** In a new or omitted condition claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:
(i) Any permanent impairment caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition; and
(ii) Any permanent work restriction that:
(I) Prevents the worker from returning to the job held at the time of injury; and
(II) Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.
(E) **In aggravation claims.** In an aggravation claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:
(i) Any permanent impairment caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition; and

(ii) Any permanent work restriction that:
(I) Prevents the worker from returning to the job held at the time of injury; and
(II) Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.
(F) **In occupational disease claims.** In an occupational disease claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:
(i) Any permanent impairment caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease; and
(ii) Any permanent work restriction that:
(I) Prevents the worker from returning to the job held at the time of injury; and
(II) Is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.
(c) **Additional documentation.** Unless there is clear and convincing evidence that an attending physician or authorized nurse practitioner has released the worker to the job held at the time of injury (for dates of injury on or after January 1, 2006) or that the worker has returned to the job held at the time of injury, all of the following is required:
(A) An accurate description of the physical requirements of the worker's job held at the time of injury, which has been provided by certified mail to the worker and the worker's legal representative, if any, either before closing the claim or at the time the claim is closed;
(B) The worker's wage established consistent with OAR 436-060;
(C) The worker's date of birth;
(D) Except as provided in OAR 436-030-0015(4)(d), the worker's work history for the period beginning five years before the date of injury to the mailing date of the Notice of Closure, including tasks performed or level of SVP, and physical demands; and
(E) The worker's level of formal education.
(3) When determining disability and issuing the Notice of Closure, the insurer must apply all statutes and rules consistent with their provisions, particularly as they relate to major contributing cause denials, worker's failure to seek treatment, worker's failure to attend a mandatory examination, medically stationary status, temporary disability, permanent partial and total disability, review of permanent partial and total disability.
(4) When issuing a Notice of Closure, the insurer must prepare and attach a summary worksheet, "Notice of Closure Worksheet," Form 2807, as described by bulletin of the director.
(5) The "Notice of Closure," Form 1644, is effective the date it is mailed to the worker and to the worker's attorney if the worker is represented, or to the worker's estate if the worker is deceased, regardless of the date on the Notice itself.
(6) The notice must be in the form and format prescribed by the director in these rules and include only the following:
(a) The worker's name, address, and claim identification information;
(b) The appropriate dollar value of any individual scheduled or unscheduled permanent disability based on the value per degree for injuries occurring before January 1, 2005 or, for injuries occurring on or after January 1, 2005, the appropriate dollar value of any "whole person" permanent disability, including impairment and work disability as determined appropriate under OAR 436-035;
(c) The body part(s) awarded disability, coded to the table of body part codes as prescribed by the director;
(d) The percentage of loss of the specific body part(s), including either the number of degrees that loss represents as appropriate for injuries occurring before January 1, 2005, or the percentage of the whole person the worker's loss represents as appropriate for injuries occurring on or after January 1, 2005;
(e) If there is no permanent disability award for this Notice of Closure, a statement to that effect;
(f) The duration of temporary total and temporary partial disability compensation;
(g) The date the Notice of Closure was mailed;
(h) The medically stationary date or the date the claim statutorily qualifies for closure under OAR 436-030-0035 or 436-030-0034;
(i) The date the worker's aggravation rights end;
(j) The appeal rights of the worker and any beneficiaries;
(k) A statement that the worker has the right to consult with the Ombudsman for Injured Workers;
(l) For claims with dates of injury before January 1, 2005, the rate in dollars per degree at which permanent disability, if any, will be paid based on date of injury as identified in Bulletin 111;
(m) For claims with dates of injury on or after January 1, 2005, the state's average weekly wage applicable to the worker's date of injury;
(n) The worker's return to work status;
(o) A general statement that the insurer has the authority to recover an overpayment;
(p) A statement that the worker has the right to be represented by an attorney; and
(q) A statement that the worker has the right to request a vocational eligibility evaluation under ORS 656.340.
(7) The Notice of Closure (Form 1644) must be accompanied by the following:
(a) The brochure "Understanding Claim Closure and Your Rights";
(b) A copy of summary worksheet Form 2807 containing information and findings which result in the data appearing on the Notice of Closure;
(c) An accurate description of the physical requirements of the worker's job held at the time of injury unless it is not required under section (2)(a) of this rule or it was previously provided under section (2)(b)(A) of this rule;
(d) The Updated Notice of Acceptance at Closure which clearly identifies all accepted conditions in the claim and specifies those which have been denied and are on appeal or which were the basis for this opening of the claim; and

(e) A cover letter that:
(A) Specifically explains why the claim has been closed (e.g., expiration of a period of suspension without the worker resolving the problems identified, an attending physician stating the worker is medically stationary, worker failure to treat without attending physician authorization or establishing good cause for not treating, etc.);
(B) Lists and describes enclosed documents; and
(C) Notifies the worker about the end of temporary disability benefits, if any, and the anticipated start of permanent disability benefits, if any.
(8) A copy of the Notice of Closure must be mailed to each of the following persons at the same time, with each copy clearly identifying the intended recipient:
(a) The worker;
(b) The employer;
(c) The director; and
(d) The worker's attorney, if the worker is represented.
(9) If the worker is deceased at the time the Notice of Closure is issued:
(a) The worker's copy of the notice must be addressed to the estate of the worker and mailed to the worker's last known address.
(b) Copies of the notice may be mailed to any known or potential beneficiaries to the worker's estate. If a copy of the notice is mailed to a beneficiary, it must be mailed by both regular mail and certified mail return receipt requested.
(10) The worker's copy of the Notice of Closure must be mailed by both regular mail and certified mail return receipt requested.
(11) An insurer may use electronically produced Notice of Closure forms if consistent with the form and format prescribed by the director.
(12) Insurers may allow adjustments of benefits awarded to the worker under the documentation requirements of OAR 436-060-0170 for the following purposes:
(a) To recover payments for permanent disability which were made prematurely;
(b) To recover overpayments for temporary disability; and
(c) To recover overpayments for other than temporary disability such as prepaid travel expenses where travel was not completed, prescription reimbursements, or other benefits payable under ORS 656.001 to 656.794.
(13) The insurer may allow overpayments made on a claim with the same insurer to be deducted from compensation to which the worker is entitled but has not yet been paid.
(14) Under ORS 656.268(10), if, after claim closure, the worker becomes enrolled and actively engaged in an approved training program under OAR 436-120, the insurer must again close the claim consistent with the following:
(a) The claim must be closed when the worker ceases to be enrolled and actively engaged in the training and:
(A) The worker is medically stationary;
(B) The worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions; or
(C) The claim otherwise qualifies for closure under OAR 436-030-0034.
(b) If the worker is medically stationary, there must be a current (within three months before closure) determination of medically stationary status.
(c) For claims with dates of injury on or after January 1, 2005, permanent disability must be redetermined for work disability only. For claims with dates of injury before January 1, 2005, permanent disability must be redetermined for unscheduled disability only.
(d) Except for claims closed under ORS 656.268(1)(c), the insurer must have sufficient information to redetermine work disability or unscheduled disability. The requirements in section (2) of this rule regarding sufficient information apply only as necessary for the redetermination, as follows:
(A) For claims with dates of injury on or after January 1, 2005, the insurer must have sufficient information to determine work disability under OAR 436-035-0012. An evaluation of the adaptability factor of work disability under OAR 436-035-0012(7) through (13) must be based on a current (within three months before closure) medical determination of the worker's residual functional capacity.
(B) For claims with dates of injury before January 1, 2005, the insurer must have sufficient information to determine unscheduled disability under OAR 436-035-0008(2). An evaluation of unscheduled disability must be based on a current (within three months before closure) medical determination.
(15) When, after a claim is closed, the insurer changes or is ordered to change the worker's weekly wage upon which calculation of the work disability portion of a permanent disability award may be based, the insurer must notify the parties and the division of the change and the effect of the change on any permanent disability award. For purposes of this rule, the insurer must complete Form 1502 consistent with the instructions of the director and distribute it within 14 days of the change.
Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.210, 656.212, 656.214, 656.268 (2015 Or Laws, Ch. 144), 656.726, 656.745

436-030-0035
Determining Medically Stationary Status
(1) A worker is medically stationary in the following circumstances:

(a) **In initial injury claims.** In an initial injury claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted conditions and direct medical sequelae of accepted conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.
(b) **In new or omitted condition claims.** In a new or omitted condition claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted new or omitted conditions and direct medical sequela of accepted new or omitted conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.
(c) **In aggravation claims.** In an aggravation claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted worsened conditions and direct medical sequela of accepted worsened conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.
(d) **In occupational disease claims.** In an occupational disease claim, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares that all accepted occupational diseases and direct medical sequela of accepted occupational diseases are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.
(2) When there is a conflict in the medical opinions as to whether a worker is medically stationary, more weight is given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and clear and concise reasoning.
(3) Where there is not a preponderance of medical opinion stating a worker is or is not medically stationary, deference will generally be given to the opinion of the attending physician. However, in cases where expert analysis is important, deference is given to the opinion of the physician with the greatest expertise in, and understanding of, the worker's medical condition.
(4) When there is a conflict as to the date upon which a worker became medically stationary, the following conditions govern the determination of the medically stationary date. The date a worker is medically stationary is the earliest date that a preponderance is established under sections (1) and (2) of this rule. The date of the examination, not the date of the report, controls the medically stationary date.
(5) The insurer must request the attending physician, as defined in ORS 656.005(12)(b)(A), to concur or comment when the attending physician arranges or refers the worker for a closing examination with another physician to determine the extent of impairment or when the insurer refers a worker for an independent medical examination. A concurrence with another physician's report is an agreement in every particular, including the medically stationary impression and date, unless the physician expressly states to the contrary and explains the reasons for disagreement. Concurrence cannot be presumed in the absence of the attending physician's response.
(6) A worker is medically stationary on the date of the examination when so specified by a physician. When a specific date is not indicated, a worker is presumed medically stationary on the date of the last examination, prior to the date of the medically stationary opinion. Physician projected medically stationary dates cannot be used to establish a medically stationary date.
(7) If the worker is incarcerated or confined in some other manner and unable to freely seek medical treatment, the insurer must arrange for medical examinations to be completed at the facility where the worker is located or at some other location accessible to the worker.
(8) If a worker dies and the attending physician has not established a medically stationary date, for purposes of claim closure, the medically stationary date is the date of death.
Statutory authority: ORS 656.268, ORS 656.726
Statutes implemented: ORS 656.268

436-035-0003
Applicability of Rules
(1) Except as provided in section (2) of this rule, these rules apply to the rating of permanent disability under ORS chapter 656 and to all claims closed on or after the effective date of these rules for workers medically stationary on or after June 7, 1995.
(2) The changes to OAR 436-035-0006 and 436-035-0013 adopted effective April 11, 2017, apply to:
(a) All notices of closure issued on or after April 11, 2017; and
(b) All requests for reconsideration pending before the Appellate Review Unit as of April 11, 2017.
(3) The rules adopted by WCD Administrative Order 93-056 apply to the rating of permanent disability for workers medically stationary on or after July 1, 1990 but before June 7, 1995, except as otherwise provided in 1995 Oregon Laws, chapter 332.
(4) The rules adopted by WCD Administrative Order 6-1988 apply to the rating of permanent disability for workers medically stationary before July 1, 1990, except as otherwise provided in 1995 Oregon Laws, chapter 332.
(5) For the purpose of reconsideration of claim closure under ORS 656.268, the rules in effect on the date of issuance of the appealed notice of closure apply to the rating of permanent disability for workers medically stationary after July 1, 1990, except as otherwise provided in 1995 Oregon Laws, chapter 332.
Statutory authority: ORS 656.726
Statutes implemented: ORS 656.005, 656.214, 656.268, 656.273, 656.726

436-035-0006
Determination of Benefits for Disability Caused by the Compensable Injury
(1) **In injury claims.** In an injury claim, permanent disability caused by the compensable injury includes disability caused by:
(a) An accepted condition; or
(b) A direct medical sequela of an accepted condition.
(2) **In new or omitted condition claims.** In a new or omitted condition claim, permanent disability caused by the compensable injury includes disability caused by:
(a) An accepted new or omitted condition; or
(b) A direct medical sequela of an accepted new or omitted condition.
(3) **In aggravation claims.** In an aggravation claim, permanent disability caused by the compensable injury includes disability caused by:
(a) An accepted worsened condition; or
(b) A direct medical sequela of an accepted worsened condition.
(4) **In occupational disease claims.** In an occupational disease claim, permanent disability caused by the compensable injury includes disability caused by:
(a) An accepted occupational disease; or
(b) A direct medical sequela of an accepted occupational disease.
Statutory authority: ORS 656.726
Statutes implemented: ORS 656.005, 656.214, 656.225, 656.268, 656.726, 656.802

436-035-0013
Findings of Impairment
(1) **Findings of impairment, generally.** Findings of impairment are objective medical findings that measure the extent to which a worker has suffered permanent loss of use or function of a body part or system.
(2) **Findings of impairment when the worker is medically stationary.** If the worker is medically stationary, findings of impairment are determined by performing the following steps:
(a) In injury claims.
(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted condition or a direct medical sequela of an accepted condition.
(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and
(C) Establish the portion of the loss caused by:
(i) Any accepted condition;
(ii) Any direct medical sequela of an accepted condition;
(iii) Any condition that existed before the initial injury incident but does not qualify as a preexisting condition;
(iv) Any preexisting condition that is not otherwise compensable;
(v) Any denied condition; and
(vi) Any superimposed condition.
Example: Accepted condition: Low back strain
Superimposed condition: pregnancy (mid-term)
Denied condition: lumbar disc herniation
In the closing examination, the attending physician describes range of motion findings and states that 10% of the range of motion loss is due to the accepted condition, 50% of the loss is due to a lumbar disc herniation, and 40% of the loss is due to the pregnancy. The worker is eligible for an impairment award for the 10% of the range of motion loss that is due to the low back strain. Under these rules, the range of motion loss is valued at 10%. 10% x .10 equals 1% impairment.
(b) **In new or omitted condition claims.**
(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.
(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and
(C) Establish the portion of the loss caused by:
(i) Any accepted new or omitted condition;
(ii) Any direct medical sequela of an accepted new or omitted condition;
(iii) In a new condition claim, any condition that existed before the onset of the accepted new medical condition but does not qualify as a preexisting condition;
(iv) In an omitted condition claim, any condition that existed before the initial injury incident but does not qualify as a preexisting condition;
(v) Any preexisting condition that is not otherwise compensable;
(vi) Any denied condition; and
(vii) Any superimposed condition.
(c) **In aggravation claims.**

(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted worsened condition or a direct medical sequela of an accepted worsened condition.(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and
(C) Establish the portion of the loss caused by:
(i) Any accepted worsened condition;
(ii) Any direct medical sequela of an accepted worsened condition;
(iii) Any condition that existed before the onset of the accepted worsened condition but does not qualify as a preexisting condition;
(iv) Any preexisting condition that is not otherwise compensable;
(v) Any denied condition; and
(vi) Any superimposed condition.
(d) **In occupational disease claims.**
(A) Identify each body part or system in which use or function is permanently lost as a result of an accepted occupational disease or a direct medical sequela of an accepted occupational disease.
(B) For each body part or system identified in paragraph (A) of this subsection, establish the extent to which use or function of the body part or system is permanently lost; and
(C) Establish the portion of the loss caused by:
(i) Any accepted occupational disease;
(ii) Any direct medical sequela of an accepted occupational disease;
(iii) Any preexisting condition that is not otherwise compensable;
(iv) Any denied condition; and
(v) Any superimposed condition.
(3) **Findings of impairment when the worker is not medically stationary.** Except for a claim closed under ORS 656.268(1)(c), if the worker is not medically stationary, findings of impairment are determined by performing the following steps:
(a) **In injury claims.**
(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted condition or a direct medical sequela of an accepted condition at the time the worker is likely to become medically stationary;
(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and
(C) Estimate the portion of the loss that is likely to be caused by:
(i) Any accepted condition;
(ii) Any direct medical sequela of an accepted condition;
(iii) Any condition that existed before the initial injury incident but does not qualify as a preexisting condition;
(iv) Any preexisting condition that is not otherwise compensable;
(v) Any denied condition; and
(vi) Any superimposed condition.
(b) **In new or omitted condition claims.**
(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition at the time the worker is likely to become medically stationary;
(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and
(C) Estimate the portion of the loss that is likely to be caused by:
(i) Any accepted new or omitted condition;
(ii) Any direct medical sequela of an accepted new or omitted condition;
(iii) In a new condition claim, any condition that existed before the onset of the accepted new medical condition but does not qualify as a preexisting condition;
(iv) In an omitted condition claim, any condition that existed before the initial injury incident but does not qualify as a preexisting condition;
(v) Any preexisting condition that is not otherwise compensable;
(vi) Any denied condition; and
(vii) Any superimposed condition.
(c) **In aggravation claims.**
(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted worsened condition or a direct medical sequela of an accepted worsened condition at the time the worker is likely to become medically stationary;
(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and
(C) Estimate the portion of the loss that is likely to be caused by:
(i) Any accepted worsened condition;
(ii) Any direct medical sequela of an accepted worsened condition;
(iii) Any condition that existed before the onset of the accepted worsened condition but does not qualify as a preexisting condition;

(iv) Any preexisting condition that is not otherwise compensable;
(v) Any denied condition; and
(vi) Any superimposed condition.
(d) **In occupational disease claims.**
(A) Identify each body part or system in which use or function is likely to be permanently lost as a result of an accepted occupational disease or a direct medical sequela of an accepted occupational disease at the time the worker is likely to become medically stationary;
(B) For each body part or system identified in paragraph (A) of this subsection, estimate the extent to which the use or function of the body part or system is likely to be permanently lost at the time the worker is likely to become medically stationary; and
(C) Estimate the portion of the loss that is likely to be caused by:
(i) Any accepted occupational disease;
(ii) Any direct medical sequela of an accepted occupational disease;
(iii) Any preexisting condition that is not otherwise compensable;
(iv) Any denied condition; and
(v) Any superimposed condition.
(4) **Age and education.** The social-vocational factors of age and education (including SVP) are not apportioned, but are determined as of the date of issuance.
(5) **Irreversible findings of impairment or surgical value.** Workers with an irreversible finding of impairment or surgical value due to the compensable injury receive the full value awarded in these rules for the irreversible finding or surgical value.
Example: Accepted condition: Low back strain with herniated disk at L5-S1 and diskectomy.
Noncompensable condition: pregnancy (mid-term)
The worker is released to regular work. In the closing examination, the physician describes range of motion findings and states that 60% of the range of motion loss is due to the accepted condition. Under these rules, the range of motion loss is valued at 10%. 10% x .60 equals 6%.
Diskectomy at L5-S1 (irreversible finding) = 9% per these rules.
Combine 9% with 6% for a value of 14% impairment for the compensable injury.
Statutory authority: ORS 656.726
Statutes implemented: ORS 656.005, 656.214, 656.268, 656.726